Table 1: **NEW PATIENT** (not seen by practice for 3 years) & **CONSULTATION** (no time limits).
Minimum Documentation Requirements
Key Components: History, Exam, Medical Decision Making
All **3** key components must be met (or exceeded) to qualify for a particular level code.
Code is determined by the lowest of the 3 components. **(left-most column).**
Time is a stand alone contributing component in specific circumstances described below.

History	**Focused**	**Expanded**	**Detailed**	**Comprehensive**	**Comprehensive**
Chief Complaint	1	1	1	1	1
History of Present Illness Location, Quality, Severity, Timing, Duration, Context, Modifying Factors, Associated Symptoms.	1	1	4	4	4
Review of Systems (14 systems) *Symptoms* NOT *Diseases*		1	2	10	10
Past, Family, and Social History 3 areas: **P**ast (illness, injury, meds, surgery, allergy) / **F**amily/ **S**ocial			1	3	3

Exam	**Focused**	**Expanded**	**Detailed**	**Comprehensive**	**Comprehensive**
Bullets (see bullet counter)	1	6	12	30	30

Medical Decision Making (2 out of 3 Data,Diagnosis,Risk)	**Straight Forward**	**Straight Forward**	**Low**	**Moderate**	**High**
Data add points (# points) (2) Interpret Imaging (2) Review/Summary record and/or curb–Side and/or Translator and/or History from other (1) Order imaging or review report (1) Order lab or review report (1) order tests (EMG, Vasc. Lab, PFT's etc.) or review report (1) Review with performing MD (1) Order old records	1	1	2	3	4
Diagnosis add points (# points) (1) Minor Problem (max of 2) (1) Established Problem—stable or better (each) (2) Estab. Prob.—worse (each) (3) New prob. no work up planned (max of 1) (4) New prob. work up planned (each)	1	1	2	3	4
Risk Management options selected, Diagnostic procedure ordered, ***Presenting problem***	Rest Ace Wrap Lab Test ***Minor (bug bite, cold)***	Rest Ace Wrap Lab Test ***Minor (bug bite, cold)***	OTC PT X-ray Arterial punt. Biopsy (superficial) ***1 problem***	Prescription Med Injection (script) Aspiration Surgery Fracture/Dislocation (no manipulation) Biopsy (deep) MRI, CT, BS X-ray 2 area ***exacerbation*** ***2 chronic probs***	Surgery with risk Emergency Surgery Fracture/Dislocation (with manipulation) Neuro Loss Discography Myelography Arthrogram Toxic Rx monitoring ***Life or limb***

Time (minimum in minutes) Must document that face to face and > 50% counseling, and summarize the counseling provided.	N 10 C 15	N 25 C 30	N 30 C 40	N 45 C 60	N 60 C 80
Code Need **3/3 key components** for Dictation. Lowest component determines code.(**or Time**)	N 99201 C 99241	N 99202 C 99242	N 99203 C 99243	N 99204 C 99244	N 99205 C 99245

Table 2: **ESTABLISHED PATIENT** (seen in practice with in 3 years) **Minimum Documentation Requirements**
Key Components: History, Exam, Medical Decision Making
Only **2** of the 3 key components must be met (or exceeded) to qualify for a particular code level.
The lower of the 2 components chosen determines code. **(left-most column of 2 components chosen).**
Time is a stand alone contributing component in specific circumstances described below.
(note: CPT code 99211 has no documentation requirements for the 3 key components.)

History	**Focused**	**Expanded**	**Detailed**	**Comprehensive**
Chief Complaint (CC on every note)	1	1	1	1
History of Present Illness Location, Quality, Severity, Duration, Timing, Context, Modifying Factors, Associated Symptoms	1	1	4	4
Review of Systems (14 systems) *Symptoms* NOT *Diseases*		1	2	10
Past, Family, and Social History 3 areas: **P**ast (illness, injury, surgery, meds, allergy) **F**amily/ **S**ocial			1	2

Exam	**Focused**	**Expanded**	**Detailed**	**Comprehensive**
Number of Bullets (see bullet counter)	1	6	12	30

Medical Decision Making (2 out of 3 Data,Diagnosis,Risk)	**Straight Forward**	**Low**	**Moderate**	**High**
Data add points (# points) (2) Interpret Imaging (2) Review/Summary record and/or curb–Side and/or Translator/ History from other (1) Order imaging or review report (1) Order lab or review report (1) order tests (EMG, Vasc. Lab, PFT's etc.) or review report (1) Review with performing MD (1) Order old records	1	2	3	4
Diagnosis add points (# points) (1) Minor Problem (max of 2) (1) Established Problem—stable or better (each) (2) Estab. Prob.—worse (each) (3) New prob. no work up planned (max of 1) (4) New prob. work up planned (each)	1	2	3	4
Risk Management options selected, Diagnostic procedure ordered, ***Presenting problem***	Rest Ace Wrap Lab Test ***Minor (bug bite, cold)***	OTC PT X-ray Arterial punt. Biopsy (superficial) ***1 problem***	Prescription Med Injection (script) Aspiration Surgery Fracture/Dislocation (no manipulation) Biopsy (deep) MRI, CT, bone scan X-rays 2 area ***exacerbation*** ***2 chronic probs***	Surgery w risk Emergency Surgery Fracture/Dislocation (with manipulation) Neuro Loss Discography Myelography Arthrogram Toxic drug monitoring ***Life or limb***

Time (minimum in minutes) Must document that face to face and > 50% counseling, and summarize the counseling provided.	10	15	25	40
Code Need **2/3 key components** for Dictation. Lower component (of top 2) determines code. (**or Time**)	99212	99213	99214	99215

Table 3: Bullet Counters

Chief Complaint Bullet counter
Every note needs chief complaint: new problems and follow ups

	History of Present Illness Bullet counter	
	Element	**Description examples**
1	Location	site of problem, diffuse, localized, radiating
2	Quality	sharp, dull, throbbing, stabbing, burning
3	Severity	pain scale
4	Duration	intermittent, constant, length of time
5	Timing	exercise, nightly, after meals, etc.
6	Context	improving, worsening, recurrent, etc.
7	Modifying Factors	what makes better, worse
8	Assoc. Symptoms	bruising, numbness, tingling, locking, swelling, etc.
Note: One bullet per numbered element described.		

	Review of Systems Bullet counter	
	System	**Symptoms examples**
1	Constitutional	unexpected weight loss, weight gain, fever, chills, fatigue
2	Eyes	corrective lenses, blurred/double vision, eye pain, redness, watering
3	ENT	headache, difficulty swallowing, nose bleeds, ringing in ears, earaches
4	Cardiovascular	chest pain, palpitations, fainting, murmurs
5	Respiratory	short of breath, wheezing, cough, tightness, inspiration pain, snoring
6	Gastrointestinal	heartburn, nausea, vomiting, constipation, diarrhea, bloody/tarry stools
7	Genitourinary	frequency, urgency, difficult / painful urination, flank pain, bleeding
8	Musculoskeletal	joint pains, swelling, instability, stiffness, redness, heat, muscle pain
9	Skin	skin changes, poor healing, rash, itching, redness
10	Neurologic	numbness/tingling, unsteady gait, dizziness, tremors, seizure
11	Psychiatric	nervousness, anxiety, depression, hallucinations
12	Hematologic	easy bleeding, bruising
13	Endocrine	excessive thirst or urination, heat/cold intolerable
14	Allergic	reaction to foods or environment

Note 1: One bullet for each system described.
Note 2: Symptoms (chest pain, shortness of breath) NOT Diseases (heart attack, COPD)
Note 3: This section may be obtained by ancillary staff or patient questionnaire. Physician to initial and date form and refer to in the evaluation.
Note 4: For follow up visits a ROS obtained at a previous visit need not be re-recorded if the physician describes any changes or notes that there has been no change in the previous information; and notes the date and location of the earlier ROS.

	Past, Family, and Social Histories Bullet Counter	
	History Area	**Examples**
1	Past History	Illnesses, hospitalizations, meds, injuries, surgeries, allergies
2	Family History	Inherited diseases, patient risk factors, medical events
3	Social History	Marital status, occupation, alcohol, tobacco, drug use

Note 1: One bullet for each of 3 history areas described.
Note 2: This section may be obtained by ancillary staff or patient questionnaire. Physician to initial and date form and refer to in the evaluation.
Note 3: For follow up visits a PFSH obtained at a previous visit need not be re-recorded if the physician describes any changes or notes that there has been no change in the previous information; and notes the date and location of the earlier PFSH.

Musculoskeletal Exam Bullet Counter				
Physical Exam Elements	Bullet count			
Vital Signs (at least 3: BP, T, P, R, Ht. Wt.)	1			
General Appearance	1			
Orientation X 3	1			
Mood and Affect	1			
Gait and Station	1			
BODY AREA (neck, back, RUE, LUE, RLE, LLE)	BA 1	BA 2	BA 3	BA 4
Inspection/Palpation	1	1	1	1
Range of Motion	1	1	1	1
Stability	1	1	1	1
Strength	1	1	1	1
Skin	1	1	1	1
CV (any 1: pulse, temp, edema, swelling, varicosities)	1			
Lymph (at least one area)	1			
Sensation	1			
DTR and Pathologic Reflexes	1			
Coordination and Balance	1			
Total	30			

Note 1: As a minimum, for a **comprehensive** exam all **4 bullets** (Inspect/palpate, ROM, Stability, and Strength) **in 4 body areas** and Skin **in 4 body areas** in addition to all other exam elements noted above must be documented.
Note 2: Documentation of multiple joints in the same body area is only 1 bullet for each descriptor (Inspect/palpate, ROM, Stability, Strength). Example, ROM of right shoulder, R elbow and R wrist is one bullet. But, ROM R shoulder, L shoulder, R knee, L knee, neck, and back is 6.

Table 4	**E/M MODIFIERS**	
Modifier	Definition	Clinical examples
24	Unrelated E/M in post op	Additional unrelated problem treated within surgery global period.
25	Significant and Separately Identifiable E/M	• Unplanned Injection on initial evaluation • Unplanned Injection on Follow up visit if significant work is spent on E/M • E/M given for another joint not injected • Can't use for planned injection
57	Decision for surgery made same day or day before a major procedure. A major procedure is defined as a surgery / procedure with 90 global days.	E/M code on first visit, with fracture package (if manipulation) or surgery global. A visit the day of or day before surgery is part of the global, unless decision for surgery is made at that visit.

References: 1. AAOS CPT Guide, 2007
2. AMA Principles of CPT coding, 2005
3. CMS 1997 Guidelines.
4. CPT 2007.
5. Karen Zupko and Associates.
6. Ritchie, Jack, Arthroscopy, Feb. 2002, supplement 1, pp 99-110.

AAOS Now, James Davidson MD, 2007
For additional information and instruction see: http://www.aaos.org/news/bulletin/may07/managing7.asp