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Appendix 1

Specialty Code	Specialty Description	Taxonomy Code	Taxonomy Description
08	Family Practice	207Q00000X	Family Practice
11	Internal Medicine	207R00000X	Internal Medicine
20	Orthopaedics	207X00000X	Orthopaedic Surgery, Adult Reconstructive Surgery, Foot and Ankle Surgery, Sports Ortho, Spine Surgery, Trauma Ortho, Pediatric Ortho
23	Sports Medicine*	207QS0010X	Family Medicine**,** Emergency Medicine, Internal Medicine, Pediatrics
25	Physical Medicine and Rehabilitation	208100000X	Physical Medicine & Rehabilitation
40	Hand†	2086S0105X	Surgery Plastic Surgery
48	Podiatry	213E00000X	Podiatrist

*Family practice sports medicine physicians may credential with CMS and insurance carriers using specialty code 08 or 23. We recommend orthopaedic sports medicine physicians, even those who have a subspecialty certification, credential using specialty code 20 because of the difficulty in differentiating sports orthopaedics and general orthopaedics, as well as profile variations. However, an orthopaedic sports medicine physician could credential in specialty 23.

† Hand surgeons may be credentialed with CMS and insurance carriers using specialty code 40 and/or specialty code 20. Physicians credentialed first or only as hand surgeons may be considered a different specialty than orthopaedics when applying the three-year rule. Hand surgeons credentialed with specialty code 20 are considered the same as the other orthopaedic surgeon.

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Table 1. NEW PATIENT & CONSULTATION [2-8,15]
***Minimum* Documentation Requirements: Key Components**: History, Exam, Medical Decision making
A**ll 3** key components must be met (or exceeded) to qualify for a coding level of service.
Code is determined by the lowest of the 3 components. **(left-most column).**
Time may be the sole determining factor 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 all as defined	30 all as defined

Medical Decision Making (2 out of 3 Data,Diagnosis,Risk)	Straight Forward	Straight Forward	Low	Moderate	High
Data add points (# points) (1) Order imaging and/or review reports (Xrays, MRI, CT or MSK DX US) (1) Order lab tests and/or review results (blood, urine, body fluid) (1) Order other test and/ or review report (EKG, NCS/EMG, doppler) (2) Independent interpretation of outside image. * there are no points given for interpreting in office films billed with a global radiology code/26 modifier (2) Review/Summary record and/or History from other/discussion with HCP (1) Review test with performing HCP (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 (1 max) (4) New prob. work up planned (each)	1	1	2	3	4
Risk Management options selected, Or Diagnostic procedure ordered Or Presenting problem	-Rest -Ace Wrap -Lab Test -Imaging w/out contrast -Minor problem (simple strain or contusion)	-Rest -Ace Wrap -Lab Test -Imaging w/out contrast -Minor problem (simple strain or contusion)	-OTC -PT -Injection no co-morbid -Imaging with IV contrast -Bone Scan -Biopsy (superficial) -1 chronic problem stable, -Acute uncomplicated injury (simple ankle sprain)	-Prescription Med -Aspiration -Surgery healthy -Fracture/Dislocation (no manipulation) -Joint injection with co-morbid (cortisone in DM) -Imaging with Arthrogram -Biopsy (deep) -1 chronic exacerbation, -2 chronic probs stable, -Acute complicated injury (ACL tear)	-Surgery with co-morbidities -Emergency Surgery -Fracture/Dislocation (with manipulation) -Life or limb -Abrupt Neuro Loss
Code Need **3/3 key components** for note. Lowest component determines code.	N 99201 C 99241	N 99202 C 99242	N 99203 C 99243	N 99204 C 99244	N 99205 C 99245

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Time (minimum in minutes) Can be stand-alone factor. 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

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Table 2: **ESTABLISHED PATIENT** [2-8,15]
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 level code.
Code is determined by the lower of the 2 components. **(left-most column of 2 components chosen).**
Time may be the sole determining factor 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	1	1	1	1
History of Present Illness Location, Quality, Severity, Timing, Duration, 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, meds, surgery, allergy) / **F**amily/ **S**ocial			1	2

Exam	Focused	Expanded	Detailed	Comprehensive
Bullets (see bullet counter)	1	6	12	30 all as defined

Medical Decision Making (2 out of 3 Data,Diagnosis,Risk)	Straight Forward	Low	Moderate	High
Data add points (# points) (1) Order imaging and/or review reports (Xrays, MRI, CT or MSK DX US) (1) Order lab tests and/or review results (blood, urine, body fluid) (1) Order other test and/ or review report (EKG, NCS/EMG, doppler) (2) Independent interpretation of outside image. * there are no points given for interpreting in office films billed with a global radiology code/26 modifier (2) Review/Summary record and/or History from other/discussion with HCP (1) Review test with performing HCP (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, Or Diagnostic procedure ordered Or Presenting problem	-Rest -Ace Wrap -Lab Test -Imaging w/out contrast -Minor problem (simple strain or contusion)	-OTC -PT -Injection, no co morbid -Imaging with IV contrast -Bone Scan -Biopsy (superficial) -1 chronic problem stable -Acute uncomplicated injury (e.g. simple ankle sprain)	-Prescription Med - Aspiration -Surgery healthy -Fracture/Dislocation (no manipulation) -Joint injection with co-morbid (cortisone in DM) -Imaging with arthrogram -Biopsy (deep) -1 chronic prob with exacerbation -2 chronic probs stable - Acute complicated injury (e.g. ACL tear)	-Surgery with co-morbidities -Emergency Surgery -Fracture/Dislocation (with manipulation) -Life or limb Abrupt Neuro Loss
Code Need **2/3 key components** for note. Lowest	99212	99213	99214	99215

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component determines code.				
Time (minimum in minutes) Can be stand-alone factor. Must document that face to face and > 50% counseling and summarize the counseling provided.	10	15	25	40

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Table 3: History Bullet Counters (Provider is billing MD, DO, PA, NP) [2-8,15]

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 1: One bullet per numbered element described.
Note 2: This must be obtained personally by the provider billing for the service

Review of Systems Bullet counter

	System	Symptoms examples - for each system list symptom or state denies
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: There must be a positive or negative comment for each system to receive credit. May state "none" or list other.
Note 4: This section may be obtained by ancillary staff or patient portal. Provider to review and electronically sign.
Note 5: For f/u visits to receive credit ROS should be updated or state no changes. Provider to review and electronically sign.
Note 6. The Provider should determine medical necessity of the number of systems being counted.

Past, Family, and Social Histories Bullet Counter

	History Area	Examples; See CPT manual for full listing
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, military, education level, current employment

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Note 1: One bullet for each of 3 history areas described.
Note 2: This section may be obtained by ancillary staff or patient portal. Provider to review and electronically sign.
Note 3: For f/u visits to receive credit ROS should be updated or state no changes. Provider to review and electronically sign
Note 4: Provider to determine medical necessity.

Table 4. Musculoskeletal Exam Bullet Counter [2-8,15]

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
Inspection/Palpation	1	1	1	1	1	1
Range of Motion	1	1	1	1	1	1
Stability	1	1	1	1	1	1
Strength	1	1	1	1	1	1
Skin	1	1	1	1	1	1

CV (any 1: pulse, temp, edema, varicosities)	1
Lymph (at least one area)	1
Sensation	1
DTR and Pathologic Reflexes	1
Coordination and Balance	1
Total	40

See " how to" paper for more info on this documentation.

Note 1: As a minimum, for a comprehensive exam all 4 bullets (Inspect/palpate, ROM, Stability, and Strength) plus Skin in 4 body areas for 20 bullets must be documented. In addition, all 10 other exam elements highlighted in grey boxes 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	Unrelated problem evaluated within surgery global period.
25	Significant and Separately Identifiable E/M	Unplanned Injection on Follow up visit if significant work is spent on E/M E/M given for another area evaluated and 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.	A visit the day of or day before surgery is part of the global, unless decision for surgery is made at that visit

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