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Appendix 2

See accompanying "how to" information for further details.
Table 1. NEW PATIENT (not seen in same practice / same specialty 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 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: Past (illness, injury, meds, surgery, allergy) / Family / Social			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
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

Example 1. Starting with **Medical Decision Making** 2 of the 3 parts, **Data**, **Diagnosis**, and **Risk** need to be met or exceeded. In this example, circled in green, there is 1 point for **Data:** order imaging (Straight Forward), 4 points for **Diagnosis** for a new problem with work up planned (High complexity) , and Moderate **Risk** for an Acute complicated injury. Moderate Risk (level 4) and High Complexity Diagnosis (level 5) are the 2 parts chosen. The lower of those two is Moderate Risk (level 4). So, overall, the MDM component is Moderate (level 4).
For a New Patient visit 3/3 key components must be met or exceeded. In this case, circled in red, the key components are a Detailed (level 3) **History** a Detailed (level 3) **Exam** and a Moderate (level 4) **Medical Decision Making**. The code is determined by the lowest of the 3 components, left most column. So this is a **99203** encounter.

- **CC:** "my left shoulder hurts" **1**
- **HPI:** Lateral deltoid pain,
- aching, pain is 7/10, X 2 weeks post lifting **4**
- **ROS:** CV:No chest pain. Neuro: No numbness **2**
- **PFSH:** Works as plumber **1**
- **PE:** A+O, appears age of 55, **13**

  Right shoulder : Skin without lesion, Tender laterally, 0-140 ROM, 3/5 motor strength, no instability. Sensation intact to light touch

  Left shoulder : Skin without lesion, Nontender, FROM, 5/5 motor strength, no instability.
- **Impression**: New patient rotator cuff tear
- **Plan:** order MRI.
- **MDM: Moderate**
- **Code: 99203**

MINIMUM documentation requirements for demonstration purposes. This does not represent suggestions for documentation or standard templates.

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See accompanying "how to" information for further details.
Table 1. NEW PATIENT (not seen in same practice / same specialty 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 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: Past (illness, injury, meds, surgery, allergy) / Family / Social			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
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

Example 2. For a New patient visit 3/3 key components must be met or exceeded. In this case the key components, circled in red, are level 3 **History,** level 2 **Exam**, and level 4 **Medical Decision Making**. The code is determined by the lowest of the 3 components, the left most column. So, this is a **99202** encounter. The difference between example 1 and example 2 is the detailed exam in example 1.

- **CC:** "my left shoulder hurts" **1**
- **HPI:** Lateral deltoid pain, aching, 7/10, X 2 weeks post lifting **4**
- **ROS:** CV:No chest pain.Neuro: No numbness **2**
- **PFSH:** Works as plumber **1**
- **PE:** Right shoulder (skin without lesion, Tender laterally, 0-140, strength 3/5, stable) sensation intact to LT, no swelling. **6**
- **Impression:** New patient rotator cuff tear
- **Plan:** order MRI.
- **MDM:** Moderate
- Code **99202**

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Example 3. In an Established Patient visit 2/3 key components must be met or exceeded. In this case the key components, circled in red, are a level 2 **History**, a level 3 **Exam** and level 2 **Medical Decision** Making. In this case, even though there is a level 2 **Exam**, the other two components are both level 2 making this a **99212** encounter.

Looking specifically at the **Medical Decision Making** component, 2 of the 3 parts, **Data**, **Diagnosis**, and **Risk** need to be met or exceeded. In this example, circled in green, there are no points for **Data**, 1 point for **Diagnosis** for an established problem improved (Straight Forward) , and Straight forward **Risk** for an a resolved injury. Straight Forward Diagnosis and Straight Forward Risk are the 2 parts chosen. So, overall, the **MDM** component is Straight Forward (level 2).

- **CC:** R ankle pain **1**
- **HPI:** The ankle is feeling better **1**
- **Exam:** Walks without limp. Skin intact. Non tender. FROM. 5/5 motor strength, No instability. **6**
- Impression: Ankle sprain resolved.
- Plan: F/U PRN.
- **MDM: Straight Forward.**
- Code: **99212**

MINIMUM documentation requirements for demonstration purposes. This does not represent suggestions for documentation or standard templates.

Table 2: **ESTABLISHED PATIENT** (seen in same practice / same specialty within 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 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: **Past** (illness, injury, meds, surgery, allergy) / **Family** / **Social**			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) (1) Established 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 component determines code.	99212	99213	99214	99215
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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Example 4. For an Established patient visit 2/3 key components must be met or exceeded. In this example,circled in red, there is a level 3 **History**, a level 2 **Physical Exam** and a level 3 **Medical Decision Making** component. Since this is an Established visit, only two key components need to be selected, and in this example, **History** and **Medical Decision Making** are chosen. So, this is a 99213 encounter.

Looking specifically at **Medical Decision Making,** 2 of the 3 parts, **Data**, **Diagnosis**, and **Risk** need to be met or exceeded. In this example, circled in green, there are 2 points for **Data** review and summarize record from Physical Therapist. 1 point for **Diagnosis**, established problem stable, Straight Forward. And Low **Risk** for management option selected, PT. Low complexity **Data** and Low **Risk** are the 2 parts chosen. So, overall, the **MDM** component is Low Complexity (level 3).

- **CC:** R knee pain and stiffness **1**
- HPI: 4 mo s/p ACL recon **2**
- **ROS:** CV: No Calf pain or swelling **1**
- **PE:** Right Knee: Nontender, 10-100 ROM, Strength 4/5, No Lachman. **4**
- **Data:** Physical Therapist's note is reviewed: Stiff and weak needs more PT
- **Impression:** Post op ACL with continued loss of strength and motion.
- **Plan:** Order PT.
- **MDM: Low.**
- **Code: 99213**

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Table 2: **ESTABLISHED PATIENT** (seen in same practice / same specialty within 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 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 workup planned (max of 1) (4) New prob. workup 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)	-PT 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 component determines code.	99212	99213	99214	99215
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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Example 5. In an established patient visit 2/3 key components must be met or exceeded. In this case, circled in red, the key components are a level 4 **History**, a level 3 **Exam** and a level 4 **Medical Decision** Making. Since this is an Established visit, only two key components need to be selected, and in this example, level 4 **History** and level 4 **Medical Decision Making** are chosen. So, this is a **99214** encounter.

Looking specifically at the **Medical Decision Making** component, 2 of the 3 parts, **Data**, **Diagnosis**, and **Risk** need to be met or exceeded. In this example, circled in green, there are 3 points for **Data** (moderate complexity), 2 points for **Diagnosis** for an established problem worse (Low complexity) , and Moderate **Risk** for surgery in a healthy patient. Moderate **Data,** and Moderate **Risk** are the 2 parts chosen. So, overall, the **MDM** component is Moderate Complexity (level 4)

- **CC:** Left knee instability **1**
- **HPI:** Follow up visit. Gives way with pivots. Sharp pain. Localized medially. Pain scale 5/10. Worsening. **5**
- **ROS:** Neuro: no numbness, CV: no calf swelling **2**
- **PFSH:** College FB **1**
- **PE:** Left knee tender medially, FROM, Lachman positive, 5/5 motor. Skin intact. Dorsalis pedis pulse palpable. Walks with limp. **7**
- **Data:** MRI reviewed independently: ACL, Medial Meniscus Tear.
  Rad. Report: ACL, MMT.
- **Impression:** ACL and MMT
- **Plan:** ACL recon. MM repair.
- **MDM:** Moderate
- **Code:** **99214**

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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, [illegible]) (1) Order lab tests and/or review results (blood, urine, body fluid) (1) Order other test and/ or review report ([illegible] doppler) (2) Independent interpretation of outside [illegible] 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 workup 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 component determines code.	99212	99213	99214	99215
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