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## The following content was supplied by the authors as supporting material and has not been copy-edited or verified by JBJS.

## Appendix 2

	See accompanying "how to" Informati Table 1. NEW PATIENT (not seen in san Minimum Documentation Requirement All 3 key components must be met (or Code is determined by the lowest of th Time may be the sole determining fact	ne practice / same s: Key Compone exceeded) to qua e 3 components.	e specialty for 3 y ints: History, Exa alify for a coding (left-most colu	am, Medical Decision ma level of service. mn).		
	History	Focused	Expanded	Detailed	Comprehensive	Comprehensive
	Chief Complaint History of Present Illness Location, Quality, Severity, Timing, Duration, Context, Modifying Factors,	1	1	1 4	4	1 4
	Associated Symptoms.  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				3	3
1	Exam	Focused	Expanded	Detailed	Comprehensive	Comprehensive
	Bullets (see bullet counter)	1	6	12	30 all as defined	30 all as defined
	Medical Decision Making	Straight	Straight			
-	(2 out of 3 Data, Diagnosis, Risk)	Forward	Forward 1	Low	Moderate 3	High 4
	(1) Order imaging anyor review reports (Xrays, MB) CT or MSK DX US) (1) Order lab tests and/or review results (blood, urine, body fluid) (1) Order lab tests and/or review results (blood, urine, body fluid) (2) Independent interpretation of outside image. * there are no points given for interpreting in office films billed with a global radiology code/26 mg/s) (2) Review/Summary record and/or History from other/discussion with HCP (1) Review/Summary record and/or History from other/discussion with HCP (1) Review test with performing HCP (1) Order old records  Diagnosis add points (# points) (1) Minor Problem (max of 2) (1) Established Problem—stable or better (each) 3) New prob. noworkup planned (1 max) (3) New prob. noworkup planned (1 max) (4) New prob. workup planned (each)	,	1	2	3	4
	Management options selected, Or Diagnostic procedure ordered Or Presenting problem	-Rest -Ace Wrap -Lab Test -Imaging wout contrast -Minor problem (simple strain or contusion)	-Rest -Ace Wrap -Lab Test -Imaging wout 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 ron manipulation) -Joint injection with co-morbid (cortisone in DM) -Imaging with Arthrogram -Biopsy (deep) -1 chronic exacerbation, -2 chronic probs states -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" informati	on for further de	tails.			
Table 1. NEW PATIENT (not seen in san Minimum Documentation Requirements	ne practice / same	e specialty for 3 y	ears) & CONSULTATION	N (no time limits)	
All 3 key components must be met (or	exceeded) to qua	alify for a coding	level of service.	inig	
Code is determined by the lowest of the Time may be the sole determining factor					
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,	1	1	4	4	4
Associated Symptoms.  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				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	Straight	Straight			
(2 out of 3 Data Diagnosis Risk)	Forward	Forward	Low	Moderate	High
Date and points (a conits) (1) Order imaging a flyfor review eports (Xrays, MRI L-T or MSK DX (1) Order lab tests and/or review expects (Xrays, MRI L-T or MSK DX (1) Order lab tests and/or review expects (blood, urine, body fluid) (1) Order other test and/ or review expects (blood, urine, body fluid) (2) Independent interpretation of outside image. There are no points given for interpretation of outside image. There are no points given for interpreting in office films billed with a global radiology coder/28 modifier (2) Review/Summary record and/or Hispory from other/discussion with 11 order of the expectation of		1	2	3	4
Diagnosis add points (# points) (1) Minor Problem (max of 2) (1) Established Problem—stable or better (each) (2) Estab Prohworse(each) oylrewprob. noworkup planned (1 max) (4) New prob. workup planned (each)	1	1	2	3	4
Management options selected, Cr Diagnostic procedure ordered Cr Presenting problem	-Rest -Ace Wrap -Lab Test -Imaging w/out contrast -Minor problem (simple strain or contusion)	-Rest -Ace Wrap -Lab Test -Imaging wout 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 (cortissone in DM) -Imaging with Arthrogram -Biopsy (deep) -1 chronic evacerbation, -2 chronic probs	-Surgery with co-morbidifies -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**

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

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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.

Impression: Ankle sprain resolved.

• Plan: F/U PRN.

MDM: Straight Forward.

Code: 99212

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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	Comprehensiv	
Chief Complaint	1	1	Detailed	1	
History of Present Illness Location, Quality, Severity, Timing, Duration, Context, Modifying Factors, Associated Symptoms.		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	Comprehensiv	
Bullets (see bullet counter)	1	6	12	30 all as define	
	Observation	Low	Moderate	Ula <sup>1</sup>	
Medical Decision Making (2 out of 3 Data, Diagnosis, Risk)	Straight Forward	Low	woderate	High	
TO Order imaging and/or review reports (Xrays, MRI, CT or MSK DX US) (1) Order lab tests and/or review results (1) Order lab tests and/or review results (1) Order offer review report (EKG, NCS/EMG, doppler) (2) Independent interpretation of outside image, there are no points given for 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					
Diagnosis add points (# points) former problem (max or 5) (f) Established Problem—stable or better (each) (3) New prob. nowork up planned (max of 1) (4) New prob. nowork up planned (each)		2	3	4	
Risk Management options selected, Cr Diagnostic procedure ordered Cr Presenting problem	-Rest -Ace Wrap -Lab Test -Imaging w/out contrast -Minor proble (simple strain o contusion)	-OTC -PT -Injection, no co morbid -Imaging with IV contrast -Bone Scan -Biopsy (superficial) -1 chronic problem stable -Acute uncomplicated	-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	-Surgery with co-morbidities -Emergency Surgery -Fracture/Dislocation ( manipulation) -Life or limb Abrupt Neuro Loss	
		injury (e.g. simple ankle sprain)	exacerbation  -2 chronic probs stable  - Acute complicated injury (e.g. ACL tear)		
Code					
Need 2/3 key components for note. Lowest component determines code.	99212	99213	99214	99215	

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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.
- 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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			nents.)	
History Chief Complaint	Focused	xpanded	Detailed	Comprehensive
History of Present Illness Location, Quality, Severity, Timing, Duration, Context, Modifying	1	1	4	4
Factors, Associated Symptoms.  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)		6	12	30 all as defined
Medical Decision Making (2 out of 3 Data, Diagnosis, Risk)	Straight Forward	Low	Moderate 3	High 4
Data and points (# points)  (1) Order inaging 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 of the test and/or review results (blood, urine, body fluid) (2) Independent interpretation of outside image, there are no points given for interpreting in office and the points of the ship of the points of the ship of the points of the ship of the points of		2	Ü	
Dlagnosis add points (#points) (pwintor Problem via: of 2) (1) Established Problem—stroller or better (2) Estab. Prob.—worse (each) (3) Newprob. mowchup planned (max of 1) (6) Newprob. workupplanned (each)		2	3	4
Risk Management options selected, Or Diagnostic procedure ordered Or Presenting problem	-Rest -Ace Wap -Lab Test -Imaging wout contrast -Minor problem (simple strain or contusion)	-PT -PT co morbid -Imaging with IV contrast -Bone Scan -Blopsy (superficial) -1 chronic problem stable -Acute uncomplicated injury (e.g. simple ankle sprain)	-Prescription Med - Aspiration near the Aspiration of the Aspirati	-Surgery with co-morbidities -Emergency Surgery -Fracture/Dislocation (v manipulation) -Life or limb Abrupt Neuro Loss
Code	99212	99213	99214	99215

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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: ModerateCode: 99214

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Minimum Documentation Requirements Key Components: History, Exam, Medica Only 2 of the 3 key components must be r Codeis determined by the lower of the 2 components Time may be the sole determining factor is (Note: CPT code 39211 has no document	al Decision Making net (or exceeded) t ents. <b>(left-most colur</b> pecific circumstanc	mn of 2 components chosen es described below.	).	
History	Focused	Expanded	Detailed	Comprehensive
Chief Complaint History of Present Illness Localion, Quality, Severity, Tming, Duration, Context, Modifying Factors, Associated Symptoms. Reviewof Systems (14systems) Symptoms Nort Diseases Past, Family, and Social History Jareas Past (liness, injury, meds, surgery,	1	1	2	10 2
allergy)/Family/Social				
Exam	Focused	Expanded	Detailed	Comprehensive
Bullets (see bullet counter)	1	6	12	30 all as defined
Medical Decision Making	Straight	Low	Moderate	High
(2 out of 3 Data Diagnosis Risk)	Forward	2		4
(1) Order lab tests and/or review results (blood, urine, body fluid) for review report (blood, urine, body fluid) for review report (blood) fluid flui				
Dlagnosis add points (# points) (1) Minor Problem (max of 2) (1) Established Problem—stable or better	1	2)	3	4
Risk Management options selected,	-Rest	-OTC	-Prescription Med -	-Surgery with
Or	-Ace Wrap	-PT	Agniroti	co-morbidities
Diagnostic procedure ordered Or	-Lab Test	-Injection, no co morbid	-Surgery healthy	-Energency Surgery -Fracture/Dislocation (v
Presenting problem	-Imaging w/out contrast -Minor problem (simple strain or contusion)	-Imaging with IV contrast -Bone Scan -Biopsy (superficial) -1 chronic problem stable	manipulation) -Joint injection with co-morbid (cortisone in DM) -Imaging with arthrogram -Biopsy (deep)	manipulation)  -Life or limb Abrupt Neuro Loss
		-Acute uncomplicated injury (e.g. simple ankle sprain)	-1 chronic prob with exacerbation -2 chronic probs stable	
			- Acute complicated injury (e.g. ACL tear)	
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	10	15	25	40