INTRODUCTION

E/M AUDIT FORM

Facility may choose to assess E/M services using audit form

**Figure 1–1** illustrates an audit form

Designed based on 1995 Guidelines for E/M Services (Documentation Guidelines, DG)

Located in Appendix B of text

May also use 1997 Guidelines for E/M Services (located in Appendix C)

Blank audit forms located in Appendix D of this text

You are to complete audit form for cases assigned CPT codes based on key components and 1995 Examination Guidelines

Report in Example 1–1 will be used to explain audit form elements

E/M LEVELS

Components that define levels of E/M services

- History (key component)
- Examination (key component)
- Medical decision making (key component)
- Counseling
- Coordination of care
- Nature of presenting problem
- Time

Key components

- History
- Examination
- Medical decision making
**HISTORY ELEMENTS**

<table>
<thead>
<tr>
<th>ELEMENT</th>
<th>Documented</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HISTORY OF PRESENT ILLNESS (HPI)</strong></td>
<td></td>
</tr>
<tr>
<td>1. Location (site on body)</td>
<td></td>
</tr>
<tr>
<td>2. Quality (characteristic; throbbing; sharp)</td>
<td></td>
</tr>
<tr>
<td>3. Severity (1/10 or how intense)</td>
<td></td>
</tr>
<tr>
<td>4. Durationa (how long for problem or episode)</td>
<td></td>
</tr>
<tr>
<td>5. Timing (when it occurs)</td>
<td></td>
</tr>
<tr>
<td>6. Context (under what circumstances does it occur)</td>
<td></td>
</tr>
<tr>
<td>7. Modifying factors (what makes it better or worse)</td>
<td></td>
</tr>
<tr>
<td>8. Associated signs and symptoms (what else is happening when it occurs)</td>
<td></td>
</tr>
<tr>
<td>a) Duration not in CPT as HPI Element TOTAL LEVEL</td>
<td></td>
</tr>
<tr>
<td><strong>REVIEW OF SYSTEMS (ROS)</strong></td>
<td></td>
</tr>
<tr>
<td>1. Constitutional (e.g., weight loss, fever)</td>
<td></td>
</tr>
<tr>
<td>2. Ophthalmologic (eyes)</td>
<td></td>
</tr>
<tr>
<td>3. Otolaryngologic (ears, nose, mouth, throat)</td>
<td></td>
</tr>
<tr>
<td>4. Cardiovascular</td>
<td></td>
</tr>
<tr>
<td>5. Respiratory</td>
<td></td>
</tr>
<tr>
<td>6. Gastrointestinal</td>
<td></td>
</tr>
<tr>
<td>7. Genitourinary</td>
<td></td>
</tr>
<tr>
<td>8. Musculoskeletal</td>
<td></td>
</tr>
<tr>
<td>9. Integumentary (skin and/or breasts)</td>
<td></td>
</tr>
<tr>
<td>10. Neurological</td>
<td></td>
</tr>
<tr>
<td>11. Psychiatric</td>
<td></td>
</tr>
<tr>
<td>12. Endocrine</td>
<td></td>
</tr>
<tr>
<td>13. Hematologic/Lymphatic</td>
<td></td>
</tr>
<tr>
<td>14. Allergic/Immunologic</td>
<td></td>
</tr>
<tr>
<td>TOTAL LEVEL</td>
<td></td>
</tr>
<tr>
<td><strong>PAST, FAMILY, AND/OR SOCIAL HISTORY (PFSH)</strong></td>
<td></td>
</tr>
<tr>
<td>1. Past illness, operations, injuries, treatments, and current medications</td>
<td></td>
</tr>
<tr>
<td>2. Family medical history for heredity and risk</td>
<td></td>
</tr>
<tr>
<td>3. Social activities, both past and present</td>
<td></td>
</tr>
<tr>
<td>TOTAL LEVEL</td>
<td></td>
</tr>
</tbody>
</table>

**EXAMINATION ELEMENTS**

<table>
<thead>
<tr>
<th>ELEMENT</th>
<th>Documented</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CONSTITUTIONAL (OS)</strong></td>
<td></td>
</tr>
<tr>
<td>• Blood pressure, sitting</td>
<td></td>
</tr>
<tr>
<td>• Blood pressure, lying</td>
<td></td>
</tr>
<tr>
<td>• Pulse</td>
<td></td>
</tr>
<tr>
<td>• Respiration</td>
<td></td>
</tr>
<tr>
<td>• Temperature</td>
<td></td>
</tr>
<tr>
<td>• Height</td>
<td></td>
</tr>
<tr>
<td>• Weight</td>
<td></td>
</tr>
<tr>
<td>• General appearance (Counts as only 1)</td>
<td></td>
</tr>
<tr>
<td><strong>BODY AREAS (BA)</strong></td>
<td></td>
</tr>
<tr>
<td>1. Head (including face)</td>
<td></td>
</tr>
<tr>
<td>2. Neck</td>
<td></td>
</tr>
<tr>
<td>3. Chest (including breasts and axillae)</td>
<td></td>
</tr>
<tr>
<td>4. Abdomen</td>
<td></td>
</tr>
<tr>
<td>5. Genitalia, groin, buttocks</td>
<td></td>
</tr>
<tr>
<td>6. Back (including spine)</td>
<td></td>
</tr>
<tr>
<td>7. Each extremity</td>
<td></td>
</tr>
<tr>
<td><strong>ORGAN SYSTEMS (OS)</strong></td>
<td></td>
</tr>
<tr>
<td>1. Ophthalmologic (eyes)</td>
<td></td>
</tr>
<tr>
<td>2. Otolaryngologic (ears, nose, mouth, throat)</td>
<td></td>
</tr>
<tr>
<td>3. Cardiovascular</td>
<td></td>
</tr>
<tr>
<td>4. Respiratory</td>
<td></td>
</tr>
<tr>
<td>5. Gastrointestinal</td>
<td></td>
</tr>
<tr>
<td>6. Genitourinary</td>
<td></td>
</tr>
<tr>
<td>7. Musculoskeletal</td>
<td></td>
</tr>
<tr>
<td>8. Integumentary (skin)</td>
<td></td>
</tr>
<tr>
<td>9. Neurologic</td>
<td></td>
</tr>
<tr>
<td>10. Psychiatric</td>
<td></td>
</tr>
<tr>
<td>11. Hematologic/Lymphatic/Immunologic</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL BA/OS</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EXAMINATION LEVEL</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exam Level</td>
<td><strong>Problem Focused</strong></td>
<td><strong>Expanded Problem Focused</strong></td>
<td><strong>Detailed</strong></td>
<td><strong>Comprehensive</strong></td>
</tr>
<tr>
<td><strong>LIMITED TO</strong></td>
<td><strong>LIMITED TO</strong></td>
<td><strong>EXTENDED TO</strong></td>
<td><strong>EXTENDED TO</strong></td>
<td><strong>GENERAL MULTI-SYSTEM</strong></td>
</tr>
<tr>
<td># of OS or OA</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

**MDM ELEMENTS**

<table>
<thead>
<tr>
<th>ELEMENT</th>
<th>Documented</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong># OF DIAGNOSIS/MANAGEMENT OPTIONS</strong></td>
<td></td>
</tr>
<tr>
<td>1. Minimal</td>
<td></td>
</tr>
<tr>
<td>2. Limited</td>
<td></td>
</tr>
<tr>
<td>3. Moderate</td>
<td></td>
</tr>
<tr>
<td>4. Extensive</td>
<td></td>
</tr>
<tr>
<td><strong>LEVEL</strong></td>
<td></td>
</tr>
<tr>
<td><strong>AMOUNT AND/OR COMPLEXITY OF DATA TO REVIEW</strong></td>
<td></td>
</tr>
<tr>
<td>1. Minimal/None</td>
<td></td>
</tr>
<tr>
<td>2. Limited</td>
<td></td>
</tr>
<tr>
<td>3. Moderate</td>
<td></td>
</tr>
<tr>
<td>4. Extensive</td>
<td></td>
</tr>
<tr>
<td><strong>LEVEL</strong></td>
<td></td>
</tr>
<tr>
<td><strong>RISK OF COMPLICATION OR DEATH IF NOT TREATED</strong></td>
<td></td>
</tr>
<tr>
<td>1. Minimal</td>
<td></td>
</tr>
<tr>
<td>2. Low</td>
<td></td>
</tr>
<tr>
<td>3. Moderate</td>
<td></td>
</tr>
<tr>
<td>4. High</td>
<td></td>
</tr>
<tr>
<td><strong>LEVEL</strong></td>
<td></td>
</tr>
</tbody>
</table>

**MDM**

<table>
<thead>
<tr>
<th>MDM Level</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of OS or management options</td>
<td>Minimal</td>
<td>Limited</td>
<td>Multiple</td>
<td>Extensive</td>
</tr>
<tr>
<td>Amount and/or complexity of data</td>
<td>Minimal/None</td>
<td>Limited</td>
<td>Moderate</td>
<td>Extensive</td>
</tr>
<tr>
<td>Risk</td>
<td>Minimal</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
</tr>
<tr>
<td><strong>MDM LEVEL</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*aTo qualify for a given type of MDM complexity, 2 of 3 elements in the table must be met or exceeded.*

**Figure 1-1.** E/M audit form based on 1995 Guidelines for E/M Services.
**EXAMPLE 1–1**

**SURGICAL CONSULTATION**
(Note: The patient had a gastrointestinal operation 4 weeks ago, but the report does not clearly indicate that the current obstruction is due to the surgical procedure, therefore, a “complication of surgery” code would not be appropriate in this case.)

LOCATION: Inpatient Hospital
PATIENT: Martin Newwell
PHYSICIAN: Alma Naraquist, MD
CONSULTANT: Daniel Olanka, MD

HISTORY OF PRESENT ILLNESS: This patient was operated on by Dr. Sanchez approximately 4 weeks ago for a misdiagnosis of appendicitis. He underwent ileocecal resection. He has had a variety of problems in the postoperative period, including renal failure, respiratory failure, tracheostomy, etc. He is currently under the care of Dr. Naraquist and is off the ventilator and breathing through the tracheostomy. He has been intermittently fed through small bowel Cor-Flo tube, but this has the appearance of a bowel obstruction. Dr. Naraquist has asked me to evaluate the patient for suspected bowel obstruction, and the family has requested that another surgeon get involved in his care. I have been asked to review his case and give recommendations.

PHYSICAL EXAMINATION: On examination, the patient is resting comfortably in bed. He does have a tracheostomy in place. He is alert and does respond. The chest is clear to auscultation. There is a catheter in place for dialysis, although the patient is not currently on dialysis. The abdomen is markedly distended. It is tympanic. Tinkling bowel sounds are heard. There are no rushes. The midline scar is well healed. There is no particular focal tenderness, and no hernias are appreciated.

Review of the patient’s films shows marked dilatation of the small bowel. Review of the CT scan shows marked dilatation of the small bowel with what appears to be a transition zone in the distal ileum. The colon is deflated.

DISCUSSION: By physical examination, this patient has chronic bowel obstruction, at least partial in nature. Certainly his x-rays support that there is a major problem intra-abdominally. My recommendation would be that the patient should be considered for re-exploration for bowel obstruction. I do not know whether the problem is at the anastomosis or near the anastomosis. I think patient would benefit from some total parenteral nutrition (TPN) and aggressive hydration over the next few days, and then we will plan to take him to the operating room next week.

Dr. Olanka, MD

---

**HISTORY**

Complete history has four components

**Chief Complaint (CC)**

Brief summary describing reason for encounter

- Usually in patient’s own words
- Required at all E/M levels
Includes
  Symptom
  Problem
  Condition
  Diagnosis
  Physician’s recommendations
  Any other significant factors

In Example 1–1
  CC is obstruction of intestine

**History of the Present Illness (HPI)**
Description of current problem
Described in order in which symptoms
  Occurred
  Have occurred since the previous encounter
Must be documented in medical record by physician

HPI elements
  Location
    Site on body (e.g., arm, leg, neck)
  Quality
    Patient’s description of problem (e.g., dull, constant, throbbing), a
    sensation or feeling
  Severity
    Patient’s description concerning pain caliber (1-10 scale or
    how intense)
  Duration
    Length of time patient has experienced symptom or episode to present
    time
  Timing
    When problem is experienced (e.g., morning, noon, when lying down),
    when started, if a pattern
  Context
    Under what circumstances does it occur (e.g., bending, standing)
  Modifying factors
    Actions patient used to treat symptoms (e.g., aspirin, antacids, heat)
  Associated signs and symptoms
    What else is happening when it occurs (e.g., stress or incontinence), related
    to main complaint
Two levels of HPI

Brief, 1-3 elements
  Problem focused and expanded problem focused levels

Extended, 4+ elements
  Detailed and comprehensive levels

In Example 1–1, the HPI elements (Figure 1–2) are:
  Location (abdomen)
  Duration (4 weeks)
  Modifying factors (tracheostomy, feeding tube)
  Associated signs and symptoms (renal failure, respiratory failure)

Level: 4 elements = extended (detailed level or comprehensive level)

The level is the same whether using either the 1995 or 1997 Documentation Guidelines

<table>
<thead>
<tr>
<th>HPI elements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Documented</td>
</tr>
<tr>
<td>X</td>
</tr>
<tr>
<td>X</td>
</tr>
<tr>
<td>X</td>
</tr>
<tr>
<td>X</td>
</tr>
<tr>
<td>X</td>
</tr>
<tr>
<td>X</td>
</tr>
<tr>
<td>X</td>
</tr>
<tr>
<td>X</td>
</tr>
<tr>
<td>TOTAL 8</td>
</tr>
<tr>
<td>LEVEL</td>
</tr>
</tbody>
</table>

Figure 1–2. HPI Elements.

**Review of Systems (ROS)**

Used to identify subjective symptoms that the patient

Deemed unimportant

Neglected to mention

May be obtained from

Questionnaire completed by patient or ancillary staff

To qualify, physician must evaluate and document in medical record
ROS aids in

- Defining problem(s)
- Clarifying differential diagnoses
- Identifying tests useful for diagnosis
- Providing physician broader knowledge of patient
  
  Assisting physician in decision regarding management options

Three types of ROS

- Problem Pertinent
  
  Inquiry about system directly identified in HPI
  
  Patient's positive/negative responses must be documented in medical record

- Extended
  
  Inquiry about system directly related to problems identified in HPI, 2-9 related body systems
  
  Patient's positive/negative responses must be documented in medical record

- Complete
  
  Inquiry about the system identified in HPI and all other systems as medically necessary

CPT recognizes the following for an ROS

- Constitutional symptoms (fever, weight loss, etc.)
- Ophthalmologic (eyes)
- Otolaryngologic (ears, nose, mouth, throat)
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary (skin)
- Neurological
- Psychiatric
- Hematologic/Lymphatic
- Immunologic

In Example 1–1, there is one ROS element

Respiratory (off the ventilator and breathing through tracheostomy)

With one element, this is a problem pertinent ROS

See Figure 1–3 for completed ROS portion of audit form

Note: The level of ROS is the same whether using the 1995 or 1997 DGs
### Past, Family, and/or Social History (PFSH)

**Past History**

Catalogues patient’s medical history

All-inclusive record of

- Past illnesses
- Operations
- Injuries
- Treatments

Specific information

Prior

- Major illnesses
- Injuries
- Operations
- Hospitalizations

Current medication(s)

Allergies (e.g., related to drug or food)

Age-appropriate

Immunization

---

<table>
<thead>
<tr>
<th>REVIEW OF SYSTEMS (ROS)</th>
<th>Documented</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Constitutional (e.g., weight loss, fever)</td>
<td></td>
</tr>
<tr>
<td>2. Ophthalmologic (eyes)</td>
<td>X</td>
</tr>
<tr>
<td>3. Otolaryngologic (ears, nose, mouth, throat)</td>
<td>X</td>
</tr>
<tr>
<td>4. Cardiovascular</td>
<td></td>
</tr>
<tr>
<td>5. Respiratory</td>
<td>X</td>
</tr>
<tr>
<td>6. Gastrointestinal</td>
<td>X</td>
</tr>
<tr>
<td>7. Genitourinary</td>
<td>X</td>
</tr>
<tr>
<td>8. Musculoskeletal</td>
<td></td>
</tr>
<tr>
<td>9. Integumentary (skin and/or breasts)</td>
<td></td>
</tr>
<tr>
<td>10. Neurological</td>
<td>X</td>
</tr>
<tr>
<td>11. Psychiatric</td>
<td>X</td>
</tr>
<tr>
<td>12. Endocrine</td>
<td></td>
</tr>
<tr>
<td>13. Hematologic/Lymphatic</td>
<td></td>
</tr>
<tr>
<td>14. Allergic/Immunologic</td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL** 7

**LEVEL**

*Figure 1–3. ROS Elements.*
Feeding
Dietary status

Family History
Identifies medical events within patient's family
Focuses on health issues of
Parents
Siblings
Children
Specific information
Causes and age of death
Parents
Siblings
Children
Specific diseases shared by family members pertaining to
CC
HPI
System review
Potential risk factors for the patient
Commonly identified with hereditary diseases

Social History
Focuses on vital age-appropriate relevant information
Specific information
Marital status
Current living arrangements
Current employment and occupational history
Use of drugs, alcohol, tobacco
Sexual history
Any other socially relevant factors

Two types of PFSH
Pertinent
Review of the history area(s) directly related to HPI
One item from any of the PFSH areas
Complete
Documentation of two or three of the PFSH areas
Sufficient for established patient in the office or other outpatient services; emergency department; subsequent nursing facility care; established patient receiving home care or domiciliary services
Documentation of one item from each of the PFSH areas

Required for new patient in the office or other outpatient services; hospital observation services; hospital inpatient services, initial care; consultations; comprehensive nursing facility assessments; new patients in the domiciliary and home care setting.

In Example 1–1, there was one PFSH element as the ileocecal resection would count as an element of the past history

This is a pertinent PFSH

See Figure 1–4 for the audit form with the PFSH portion completed

Note: The level of PFSH is the same whether using the 1995 or 1997 Documentation Guidelines

**Four History Levels**

Based on amount of data gathered

Clinical judgment of physician determines extent of history

**Problem Focused**

Centers on CC

Brief history of present illness/problem (1-3 elements)

Reviews pertinent information of CC in terms of

Severity

Duration

Symptoms

Does not include a PFSH or ROS

**Expanded Problem Focused**

Focused on CC

Brief history of present illness/problem (1-3 elements)

Review of organ system associated with CC

![Figure 1–4. PFSH Elements.](image-url)
**Detailed**

CC
Extended HPI
Pertinent system review (4+ elements)
Related systems reviewed
   Documentation shows positive and negative responses regarding multiple organ systems (total of 2-9 systems reviewed)
Pertinent PFSH
   Related to CC

**Comprehensive**

CC
Extended HPI (4+ elements)
Review of all body systems (at least 10)
Complete PFSH (2 or 3 dependent on the type of service)

In Example 1–1, the following elements were present:
   HPI: Extended
   ROS: Pertinent
   PFSH: Pertinent
   Level: Expanded Problem focused

See Figure 1–5 for the audit form with the History level assigned

**Requirements for History Levels**

**Problem-Focused History**

1-3 HPI elements
No ROS
No PFSH

**Expanded Problem-Focused History**

1-3 HPI elements
Problem-pertinent ROS (1 system)
No PFSH

<table>
<thead>
<tr>
<th>History Level</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>HPI Problem Focused</td>
<td>Brief 1-3</td>
<td>Expanded Problem Focused</td>
<td>Detailed</td>
<td>Comprehensive</td>
</tr>
<tr>
<td>ROS</td>
<td>None</td>
<td>Problem pertinent 1</td>
<td>Extended 2-9</td>
<td>Complete 10+</td>
</tr>
<tr>
<td>PFSH</td>
<td>None</td>
<td>None</td>
<td>Pertinent 1</td>
<td>Complete 2-3</td>
</tr>
</tbody>
</table>

**Figure 1–5.** History level assigned.
Detailed History
4+ HPI elements
Extended ROS
  2-9 ROS systems
Problem-pertinent PFSH
  1 history element

Comprehensive History
4+ HPI elements
Comprehensive ROS (10+ systems)
Complete PFSH (except emergency department, 99285, 2 of 3) and established patients, 2 of 3

To qualify for a given level of history, all elements must be met

Additional Guidelines for Documenting History
CC, ROS, and PFSH may be listed separately or included in HPI
If during a previous encounter a ROS and/or PFSH have been recorded, the provider must note the date and location of the earlier ROS
  The ROS and/or PFSH does not need to be re-recorded
  Physician must indicate review of ROS and/or PFSH and any updates
Questionnaire completed by ancillary staff or patient considered valid for ROS and/or PFSH if
  Physician review is documented and dated in medical record
If patient or other source is unable to provide history
  Medical record must describe patient’s condition or circumstance
  Document the reason for patient/other source not providing HPI

Another Example of History Level
CC: Right elbow pain
HPI: The patient is a 44-year-old female who states she has had worsening pain in her right elbow (location) for 2 weeks (duration). The pain is described as stabbing (quality) and is worse after knitting (context). She experiences some relief with ice and acetaminophen (modifying factors).
ROS: Constitutional: No fevers or weight change within the past 3 months
  Musculoskeletal: Negative for muscle or joint pain
  Skin: No rashes, complains of mild dryness
PFSH: Positive for hyperthyroidism (past history) which is controlled with Synthroid (medication)
**History Level**

HPI elements: 5 equal an extended HPI
- Location (right elbow)
- Duration (2 weeks)
- Quality (stabbing)
- Context (knitting)
- Modifying factors (ice, acetaminophen)

ROS: 3 meets the requirements of a detailed ROS
- Constitutional symptoms
- Musculoskeletal
- Integumentary (skin and/or breasts)

PFSH: 1 meets pertinent PFSH
- Past history revealed a thyroid condition controlled with medication
- No mention of a family or social history

Detailed history includes
- Extended HPI
  - 4 or more elements
  - Or status of 3 or more chronic and/or inactive conditions (1997 Guidelines)
- Extended ROS
  - 2-9 systems
- Pertinent PFSH
  - 1 element

Case report meets requirements of a detailed history with
- Extended HPI
- Extended ROS
- Pertinent PFSH

---

**Note:** The level of History level is the same whether using the 1995 or 1997 Documentation Guidelines

---

**EXAMINATION**

Objective portion of the encounter
- Performed by the medical provider
- Level of examination based on clinical judgment and nature of the presenting problem(s)

**Examination Levels**

**Problem Focused**
- Limited to affected body area (BA)/organ system (OS) identified by CC
  - 1 BA/OS
Expanded Problem Focused
Limited examination of BA(s) or OS(s) identified by CC and other related BA(s)/OS(s)
2-7 BA/OS

Detailed
Extended examination of affected BA(s) and OS(s) and other symptomatic or related OS(s)
2-7 BA/OS

Comprehensive
General multisystem examination OR complete examination of single organ system
8+ OS
The 1995 Guidelines state that the comprehensive examination must include at least 8 organ systems. Body areas and organ systems can only be combined for lower levels of examination.
The 1995 Documentation Guidelines recognize the following body areas:
   - Head, including the face
   - Neck
   - Chest, including breasts and axillae
   - Abdomen
   - Genitalia, groin, buttocks
   - Back, including spine
   - Each extremity
For purposes of examination the following organ systems are recognized:
   - Constitutional (vital signs, general appearance)
     Note: The CPT guidelines do not recognize constitutional as an OS
   - Eyes
   - Ears, nose, mouth and throat
   - Cardiovascular
   - Respiratory
   - Gastrointestinal
   - Genitourinary
   - Musculoskeletal
   - Skin
   - Neurologic
   - Psychiatric
   - Hematologic/lymphatic/immunologic
FROM EXAMPLE 1–1

PHYSICAL EXAMINATION:
On examination, the patient is resting comfortably in bed. He does have a tracheostomy in place. He is alert and does respond. The chest is clear to auscultation. There is a catheter in place for dialysis, although the patient is not currently on dialysis. The abdomen is markedly distended. It is tympanic. Tinkling bowel sounds are heard. There are no rushes. The midline scar is well healed. There is no particular focal tenderness, and no hernias are appreciated.

Review of the patient’s films shows marked dilatation of the small bowel. Review of the CT scan shows marked dilatation of the small bowel with what appears to be a transition zone in the distal ileum. The colon is deflated.

In Example 1–1, using the 1995 Documentation Guidelines, the physical examination includes 5 OSs examined: constitutional element (general appearance, resting comfortably, tracheostomy in place), respiratory (clear to auscultation), gastrointestinal (tympanic, tinkling bowel sounds, marked distension), skin (midline scar is well-healed), and psychiatric (he is alert and does respond). There were no BAs reviewed. There is a total of 5 BAs/OSs. This is a level 3 or detailed examination. See Figure 1–6 for completed audit form for the examination portion of the audit form.

MEDICAL DECISION MAKING (MDM)

Complexity of MDM addresses the complications involved in
   Establishing a diagnosis and/or
   Selecting a management option(s)
   Risk of potential complications associated with the patient’s presenting problem

Factors in MDM Process
Number of possible diagnoses and/or management options
Information from medical records, diagnostic tests, and other relevant information must be
   Obtained
   Reviewed
   Analyzed
Factors associated with patient’s presenting problem, the diagnostic procedures, and the possible management options
   Risk of significant complications
   Morbidity
   Mortality
   Comorbidities

Four Types of MDM
2 of 3 elements must be met or exceeded to assign the level
   Straightforward decision making involves
       Minimal number of diagnoses or management options
### Examination Elements

#### Constitutional (OS)
- Blood pressure, sitting
- Blood pressure, lying
- Pulse
- Respirations
- Temperature
- Height
- Weight
- General appearance

*Counts as only 1*

#### Body Areas (BA)
1. Head (including face)
2. Neck
3. Chest (including breasts and axillae)
4. Abdomen
5. Genitalia, groin, buttocks
6. Back (including spine)
7. Each extremity

#### Organ Systems (OS)
1. Ophthalmologic (eyes)
2. Otolaryngologic (ears, nose, mouth, throat)
3. Cardiovascular
4. Respiratory
5. Gastrointestinal
6. Genitourinary
7. Musculoskeletal
8. Integumentary (skin)
9. Neurologic
10. Psychiatric
11. Hematologic/Lymphatic/Immunologic

#### Total BA/OS

<table>
<thead>
<tr>
<th>Exam Level</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem Focused</td>
<td>Limited to affected BA/OS</td>
<td>Limited to affected BA/OS &amp; other related OS(s)</td>
<td>Extended of affected BA(s) &amp; other related OS(s)</td>
<td>General multi-system (OSs only)</td>
</tr>
<tr>
<td># of OS or BA</td>
<td>1</td>
<td>2-7 limited</td>
<td>2-7 extended</td>
<td>8+</td>
</tr>
</tbody>
</table>

#### Examination Level

**Figure 1-6.** Examination portion of audit form.
Amount and/or complexity of data is minimal or nonexistent
The risk of complications and/or of morbidity or mortality are minimal

Low-complexity decision making involves
Limited number of diagnosis or management options
Amount of data limited in scope and complexity
Low risk of complications and/or morbidity or mortality

Moderate-complexity decision making involves
Multiple diagnoses and management options available
Moderate amount of data and complexities
Moderate risk of complications and/or morbidity

High-complexity decision making involves
Extensive management options and diagnoses
Extensive amount and complexity of data
High risk of complications and/or morbidity

Guidelines used to document management options
Each encounter requires documentation that is explicitly stated or implied, and describes an assessment, clinical impression, or diagnoses

For a presenting problem WITH an established diagnosis, the documentation should indicate the problem is either

- Improved, well controlled, resolving, or resolved
- OR
- Inadequately controlled, worsening or failing to change

For a presenting problem WITHOUT an established diagnosis, the assessment is recorded in the context of a differential diagnosis

Commonly used terms are
- Possible
- Probable
- Rule out

Any initiation of or change in a treatment should be documented
Changes in management options include those in
- Either patient or nursing care instructions
- Any therapies
- Medication usage changes

When a referral is made, documentation should show the following
- Consultation(s) requested or advice that has been sought
- To whom or where the request has been made
- The origination of the request
In Example 1–1, using the 1995 Documentation Guidelines, the MDM includes extensive diagnosis and management options, limited data (review of the patient’s films and CT scan), and high risk to the patient. The patient does have a chronic condition (chronic bowel obstruction), is breathing through a tracheostomy, and is going to have another major surgery at a time when he is not yet recovered from his prior surgery. This would indicate a high risk.

See Figure 1–7 with the audit form completed and with the Medical Decision Making portion of the form completed.

When considering all levels on this case, when using the 1995 Documentation Guidelines, (See Figure 1–8 for completed form), the level of the E/M service is 99252.

<table>
<thead>
<tr>
<th>MDM ELEMENTS</th>
<th>Documented</th>
</tr>
</thead>
<tbody>
<tr>
<td># OF DIAGNOSES/MANAGEMENT OPTIONS</td>
<td></td>
</tr>
<tr>
<td>1. Minimal</td>
<td></td>
</tr>
<tr>
<td>2. Limited</td>
<td></td>
</tr>
<tr>
<td>3. Multiple</td>
<td>X</td>
</tr>
<tr>
<td>4. Extensive</td>
<td></td>
</tr>
<tr>
<td><strong>LEVEL</strong></td>
<td>3</td>
</tr>
<tr>
<td>AMOUNT AND/OR COMPLEXITY OF DATA TO REVIEW</td>
<td></td>
</tr>
<tr>
<td>1. Minimal/None</td>
<td></td>
</tr>
<tr>
<td>2. Limited</td>
<td>X</td>
</tr>
<tr>
<td>3. Moderate</td>
<td></td>
</tr>
<tr>
<td>4. Extensive</td>
<td></td>
</tr>
<tr>
<td><strong>LEVEL</strong></td>
<td>3</td>
</tr>
<tr>
<td>RISK OF COMPLICATION OR DEATH IF NOT TREATED</td>
<td></td>
</tr>
<tr>
<td>1. Minimal</td>
<td></td>
</tr>
<tr>
<td>2. Low</td>
<td></td>
</tr>
<tr>
<td>3. Moderate</td>
<td>X</td>
</tr>
<tr>
<td>4. High</td>
<td></td>
</tr>
<tr>
<td><strong>MDM LEVEL</strong></td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MDM*</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Straightforward</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
</tr>
<tr>
<td>Number of DX or management options</td>
<td>Minimal</td>
<td>Limited</td>
<td>Multiple</td>
<td>Extensive</td>
</tr>
<tr>
<td>Amount and/or complexity of data</td>
<td>Minimal/None</td>
<td>Limited</td>
<td>Moderate</td>
<td>Extensive</td>
</tr>
<tr>
<td>Risks</td>
<td>Minimal</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
</tr>
<tr>
<td><strong>MDM LEVEL</strong></td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*To qualify for a given type of MDM complexity, 2 of 3 elements in the table must be met or exceeded.

Figure 1–7. Medical decision making portion of audit form.
**History of Present Illness (HPI)**

<table>
<thead>
<tr>
<th>Element</th>
<th>Documented</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location (site on body)</td>
<td>X</td>
</tr>
<tr>
<td>Quality (characteristic; throbbing, sharp)</td>
<td>X</td>
</tr>
<tr>
<td>Severity (1/10 or how intense)</td>
<td>X</td>
</tr>
<tr>
<td>Duration* (how long for problem or episode)</td>
<td>X</td>
</tr>
<tr>
<td>Timing (when it occurs)</td>
<td>X</td>
</tr>
<tr>
<td>Context (under what circumstances does it occur)</td>
<td>X</td>
</tr>
<tr>
<td>Modifying factors (what makes it better or worse)</td>
<td>X</td>
</tr>
<tr>
<td>Associated signs and symptoms (what else is happening when it occurs)</td>
<td>X</td>
</tr>
</tbody>
</table>
*Duration not CPT as an HPI Element

**CPT Level**

<table>
<thead>
<tr>
<th>Level</th>
<th>Documented</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>

**Review of Systems (ROS)**

<table>
<thead>
<tr>
<th>System</th>
<th>Documented</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal/Neurological</td>
<td>X</td>
</tr>
<tr>
<td>Ophthalmologic (eyes)</td>
<td>X</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>X</td>
</tr>
<tr>
<td>Respiratory</td>
<td>X</td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>X</td>
</tr>
<tr>
<td>Genitourinary</td>
<td>X</td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td>X</td>
</tr>
<tr>
<td>integumentary (skin and/or breasts)</td>
<td>X</td>
</tr>
<tr>
<td>Neurological</td>
<td>X</td>
</tr>
<tr>
<td>Psychiatric</td>
<td>X</td>
</tr>
<tr>
<td>Endocrine</td>
<td>X</td>
</tr>
<tr>
<td>Hematologic/Lymphatic</td>
<td>X</td>
</tr>
<tr>
<td>Allergic/Immunologic</td>
<td>X</td>
</tr>
</tbody>
</table>

**Total**

<table>
<thead>
<tr>
<th>Level</th>
<th>Documented</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>

**Past, Family, and/or Social History (PFSH)**

<table>
<thead>
<tr>
<th>Element</th>
<th>Documented</th>
</tr>
</thead>
<tbody>
<tr>
<td>Past illness, operations, injuries, treatments, and current medications</td>
<td>X</td>
</tr>
<tr>
<td>Family medical history for heredity and risk</td>
<td>X</td>
</tr>
<tr>
<td>Social activities, both past and present</td>
<td>X</td>
</tr>
</tbody>
</table>

**Total**

<table>
<thead>
<tr>
<th>Level</th>
<th>Documented</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

**History Level**

<table>
<thead>
<tr>
<th>Level</th>
<th>Documented</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>

**Comprehensive**

**Exam Level**

<table>
<thead>
<tr>
<th>Level</th>
<th>Documented</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>

**DMF**

<table>
<thead>
<tr>
<th>Level</th>
<th>Documented</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>

**Number of Key Components**

<table>
<thead>
<tr>
<th>Component</th>
<th>Documented</th>
</tr>
</thead>
<tbody>
<tr>
<td>Min/Max</td>
<td></td>
</tr>
</tbody>
</table>

**Exam Level**

<table>
<thead>
<tr>
<th>Level</th>
<th>Documented</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>

**History:** Comprehensive

**Examination:** Detailed

MDM: Moderate

Number of Key Components: 3 of 3

Code: 99243

**Figure 1-8.** Completed audit form for Example 1–1.
COUNSELING

Some aspect of counseling will usually take place during physician-patient encounters
One or more of following items are present in discussion with patient, family members, and/or caregivers
   Diagnostic results, impressions, and/or recommended diagnostic studies
   Prognosis of CC
   Management options presented with
      Potential risks and/or benefits
   Instructions given for
      Treatment of the CC
      Follow-up directions
   Communication explaining importance of patient following through with management/treatment option(s)
   Discussion of risk factor reduction
   Education (patient and/or family) regarding the physician’s clinical judgment(s)

COORDINATION OF CARE

Physician makes arrangements to provide the patient with additional services from other agencies or healthcare providers

NATURE OF THE PRESENTING PROBLEM (FOUNDATION)

Actual CC/situation for which physician makes a clinical judgment concerning appropriate level of care to diagnose and treat patient
Medical record should include physician’s observations regarding the level of care determined necessary to diagnose and treat patient
CPT describes the present problem by using the following terms
   Disease
   Condition
   Illness
   Injury
   Symptom
   Sign
   Findings
   Complaints
   Or other reason for the encounter
A diagnosis need not be made during the physician-patient encounter for these terms to be used
TYPES OF PRESENTING PROBLEMS

**Minimal**
May/may not require the presence of physician
Service provided must be done under the physician’s supervision
   Example: Blood pressure readings, dressing changes

**Self-Limited**
Also known as minor presenting problem
Problem
   Follows normal course
   Is transient, and
   Does not permanently alter patient’s health status
Good prognosis possible with proper management and compliance

**Low Severity**
Risk of morbidity without treatment is minimal
Full recovery is likely
No indication of future health impairment

**Moderate Severity**
Risk of morbidity without treatment exists
Prognosis uncertain
Possibility of future impairment exists

**High Severity**
Risk of morbidity without treatment is very high/extremely likely
Moderate to high risk/morbidity
Presenting problem in which severe, prolonged, and functional impairment is highly probable

**TIME**

“Time” in E/M code description is not meant to be precise measurement tool
Estimated amount of time based on the average physician-patient encounter
Used to aid in determining level of service only when 50% or more of the time involves counseling and/or coordination of care

**Three Measures of Time**

**Direct Face-to-Face Time**
Describes office visits, outpatient visits, and office consultations
Refers to the time the physician actually spends in the presence of patient and/or family and/or other caregivers
Typical face-to-face time includes obtaining history and performing examination of patient and counseling
Non Face-to-Face Time

Time spent by physician before/after encounter

While this information is not specifically addressed with E/M codes, it is factored in calculations of time based E/M codes upon physician’s surveys.

Face-to-face time stated in E/M codes reflects the physician’s work before, during, and after physician-patient encounter.

Non–face-to-face time is not calculated for code selection of face-to-face time in outpatient setting.

Unit/Floor Time

Time spent by physician at the hospital unit

Time the physician provides direct bedside services to patient.

Further Time

Intra-service time is face-to-face time during which the physician

- Reviews the patient chart
- Conducts the examination
- Engages in discussion with other professionals concerning patient
- Communicating with patient’s family and/or caregivers

Time is not a descriptive element to be used when evaluating emergency department services due to the difficulties involving the physician’s multiple encounters with a variety of patients. The emergency department codes do not have “time” in code descriptors. Time is not considered in the selection of E/M codes unless it specifically addresses counseling/coordinating care. The amount of time spent face-to-face between the provider and the patient must be documented in addition to the amount of time spent in counseling and/or coordination.

**Most important question to answer with time in E/M codes:**

Did the counseling and/or coordination of care comprise more than 50% of the visit?

If counseling and/or coordination of care did not comprise 50% or more of the visit, then the level of service selected would be based on the level of history, examination, and MDM.

E/M CODES

1. **OFFICE OR OTHER OUTPATIENT SERVICES (99201-99215)**

Two subcategories of problem-focused patients

- **New patient** is one who has
  - Never had face-to-face health care services provided by the physician or anyone in the same group of the specialty
  - Not sought face-to-face care from either the physician or someone in the same group of the same specialty for at least 3 years
**Established patient** is one who has

- Received face-to-face services within the last 3 years from the physician or from another physician of the same specialty in the same group practice

Criteria that must be documented in the medical record as having been met or exceeded

- New patient
  - 3 of 3 key components must be met or exceeded
- Established patient
  - 2 of 3 key components must be met or exceeded

Note: These codes should never be used to report “annual asymptomatic physicals” or “well-child” visits

Patients receiving care are considered to be outpatients unless admitted to a health care inpatient facility

If directly admitted to a health care facility during the course of physician/patient encounter

- Services performed by physician are considered part of initial hospital care service when all records have same date
- Initial office visit or outpatient encounter would not be reported
- Bundled into initial hospital care code

Admitting physician must record all services related to admission

- Including those that occurred prior to admission when services were same date as the admission
PRACTICE 1, OFFICE OR OTHER OUTPATIENT SERVICES

Now it is time to put this information to practice by coding two reports. The first report is multiple choice and you are to select the correct choice to report the services provided and diagnosis(es) documented in the report.

The second report is fill-in-the-blank in which you assign the CPT service and ICD-9-CM diagnosis codes. Be certain to complete an audit form for each of the fill-in-the-blank reports in which the code selection is based on key components.

Once you have coded the two cases, check your answers in the answer key at the end of this PDF, where you will locate the answers and rationales.

Practice 1, Report A

LOCATION: Outpatient Clinic

Brooke is a 7-year-old established patient who presents to the clinic today with a cough that she has had for more than a week. It is definitely worse at night; however, it is there all the time. It is quite harsh and she is having productive green sputum. She has had a low-grade temperature and has not really felt very well.

PHYSICAL EXAMINATION reveals both tympanic membranes are normal. Her nose is clear. Throat is clear. Lungs are really coarse in both bases. There is an occasional wheeze. Heart has a normal sinus rhythm without murmur.

IMPRESSION: Acute Bronchitis.

We gave her a prescription for Zithromax Z-Pak liquid 200 mg/5 cc 2 teaspoons today and then 1 teaspoon daily for the following 4 days. We will see how she does. If she has difficulty next week, we will recheck her.

A. 99212; 466.0
B. 99213; 466.0, 786.2
C. 99213; 466.0
D. 99202; 466.0

Practice 1, Report B

LOCATION: Outpatient, Clinic


This is a woman well known to me 4 months status post open cholecystectomy for gallstone pancreatitis. She had some fevers and gastrointestinal pain. Presents today with GI pain (abdomen) generalized. CT scan of the abdomen shows a persistent pseudocyst. No hydronephrosis, gross abscess. She looks better today. Her abdomen is soft.

ASSESSMENT AND PLAN: A 44-year-old woman presents with acute recurrent pancreatitis and generalized abdominal pain. CT scan showing pseudocysts, but no frank abscess. I will have her continue her Augmentin and I would like to see her again in 1 week.

Codes:
2. HOSPITAL OBSERVATION SERVICES (99217-99220, 99224-99226, 99234-99236), OUTPATIENT CARE

Purpose of patient observation is to determine the severity of patient’s condition
Patient’s illness does not meet acute inpatient criteria
Codes apply to either new or established patients
All codes are based on level of services provided
All codes require 3 of 3 key components be met
When patient status changes from observation status to inpatient status on the same date, the observation is not reported separately
Rather bundled into initial hospital admission service
Codes do not apply to post-surgery care (RPPR = Routine post procedure recovery)
That care is part of surgical package and not reported separately
Three subcategories of codes
Observation Care Discharge Services
Subsequent Observation Care
Initial Observation Care
PRACTICE 2, HOSPITAL OBSERVATION SERVICES

Once you have coded the two cases, check your answers in the answer key at the end of this PDF, where you will locate the answers and rationales.

Practice 2, Report A

LOCATION: Outpatient, Hospital

REASON FOR ADMISSION: Hyperglycemia, diabetic renal disease.

HISTORY OF PRESENT ILLNESS: The patient is well-known to me. He has end-stage renal disease and is on CAPD. I was called by his daughter last night informing me that a couple of days ago he was driving in bad weather and he went in the ditch. There have been lots of problems at his home with his wife and the daughter was worried about him and was wondering if he needs to be admitted. His wife states the patient’s father struggled with depression in his later years.

I was called by the emergency room staff for guidance. His son-in-law brought him to the emergency room. At that time, the patient was seen by the emergency physician and myself. He seemed to have been oriented x 3 without any focal neurological deficits and vital signs were stable. He had some edema in the lower extremities but he was walking and talking. His STATs were maintained. His PO2 was 65. His chest x-ray showed bilateral infiltrates which seemed to be getting better. His blood sugar was 895 and a couple of hours later went up to 1,468. Magnesium was 1.3 and phosphorus was 6.2.

His white count was only 11,000. Hemoglobin was 9.5. He had some metamyelocytes and myelocytes in his differential with eosinophilia.

After long discussions with the patient and his son-in-law, we convinced him to be admitted for observation to control his blood glucose at least and be discharged the next morning. I also found out yesterday that he had a prior M-spike on serum protein electrophoresis suggestive of a multiple myeloma. This was ordered because of elevated protein and low albumin in addition to a prior episode of hypercalcemia.

He has not been compliant with his medications and probably more ignorant of how to manage insulin rather than compliance issues for his type II diabetes. He had some personality changes over the past 2 months.

The patient expressed sorrow and he was depressed and cried a couple of times in the emergency room and was concerned about the situation at home. He was not suicidal at the time I saw him in the emergency room. Obviously, his sugar was elevated because he did not take his insulin all day and was eating cookies and candy all the day, in addition to his peritoneal dialysis fluid.

Finally, the patient agreed to be admitted for observation. His blood sugar will be controlled with 20 units of regular insulin IV and insulin drip and he will be discharged in the morning. The patient has uncontrolled D.M. with renal complication on dialysis.

Because of chronic cough and the infiltrates, he is scheduled to have CT scan next week. I will have to also schedule him to see our hematologist/oncologist to do a bone marrow aspiration and biopsy.

A. 99220; 250.82, 585.6, 786.2, 793.1, 790.99, V45.11
B. 99218; 99354, 99355 ×3, 250.82, 585.6, 786.2, 793.1, 790.99, V45.11
C. 99218; 250.42, 585.6, 790.99, V45.11
D. 99218; 250.42, 583.81, 585.6, 786.2, 793.1, 790.99, V45.11
Practice 2, Report B

LOCATION: Outpatient, Hospital (Observation status)

DIAGNOSES:
1. Chronic renal failure secondary to hypertensive renovascular disease.
2. Renovascular disease.
3. Right-sided renal artery stent re-stenosis post angioplasty and placement of new stent by interventional radiology.
5. Longstanding renovascular hypertension.
6. Hypotension secondary to angioplasty and stent placement of the right renal artery and peri-procedure bleeding.

HOSPITAL COURSE: The patient is an 87-year-old female known to have chronic renal failure and renovascular disease with right-sided renal artery stenosis with previous in-stent restenosis. She had her procedure done on the day of admission. She had blood pressure of 70 systolic afterwards with some peri-procedure bleeding at the site in the right inguinal area but she did not seem to have any hematoma. She was asymptomatic with her low blood pressure. Her antihypertensive medications were held. The patient was given IV fluids. Her hemoglobin was monitored. She was around 8.8 to 9.3 grams.

On the day of discharge her hemoglobin was 8.8. Her creatinine has come down to 1.4 with a BUN of 31, sodium of 143, chloride of 117, bicarb of 21.1, and glucose of 94.

The patient was asymptomatic on this day of discharge and she was discharged in good general condition.

DISCHARGE PLAN:
1. The patient will not be on any antihypertensive medications at least until I see her again next week. Altace and Toprol both will be on hold.
2. Return to clinic next week with basic panel and CBC before her appointment.
3. I have advised her to contact me immediately if she has dizzy spells or if she has any questions or any problems. She knows how to contact me.

Codes:
3. HOSPITAL INPATIENT SERVICES (99221-99239)

**Attending physician** is one who is
Qualified on the basis of education and training and has staff membership/appointment and is therefore
Qualified to oversee patient care
Authorized to order/perform therapeutic/diagnostic procedures

Codes apply to patients officially admitted into the hospital
Key components of history, examination, and MDM determine code assignment

**Subcategories**

**Initial Hospital Care**
Must match the admission date listed by the hospital
Codes only used by admitting physician
Any service performed by physician in a setting other than the hospital on the day the patient was admitted is considered when assigning admission code
Requires 3 of 3 key components be met

**Subsequent Hospital Care**
Codes apply to services rendered to patient after admission date
Requires 2 of 3 key components be met or exceeded
History component in this subcategory reflects any new information that has been recorded in interval since most recent physician/patient encounter
Three levels of service are recognized
When the patient is stable or demonstrates improvement (99231)
When the patient has experienced a relatively minor complication or is not responding to current therapy as desired (99232)
When patient is significantly unstable or has developed either serious complications or new problem(s) (99233)
These codes can be used by physicians other than admitting physicians when physicians provide different services from the admitting physician on the same day

**Hospital Discharge Services**
Apply to time spent by attending physician when discharging the patient
Time based codes
Two levels
30 minutes or less, and more than 30 minutes
Time must be documented to report 99239
Include following services when applicable
Final patient examination
Discussion about patient’s hospital stay
Discussion with the family and/or caregiver regarding continuing care
Paperwork for discharge records
Prescriptions
Referral forms
Patient is deceased and the above mentioned services were provided
PRACTICE 3, HOSPITAL INPATIENT SERVICES

Once you have coded the two cases, check your answers in the answer key at the end of this PDF.

Practice 3, Report A

LOCATION: Inpatient, Hospital

CHIEF COMPLAINT: Extreme shortness of breath for the last 8-10 days.

HISTORY OF PRESENT ILLNESS: Lewis is a 33-year-old white male, well known to me, who came to the office this morning and was sent directly to the hospital with a complaint of progressively worsening shortness of breath for the last 10 days. It has gotten to the point he cannot even walk from the house to the mailbox without having to stop to catch his breath. He even gets short of breath while changing his clothes or during routine activities inside the house. He even gets short of breath while just sitting and talking. He denies any productive cough, fever, chest pains, or any other problems. His symptoms are mainly located in the chest, all the time. He describes it as tightness around his chest and he has difficulty breathing. Exertion makes it worse, rest makes it feel better. He rates it as a 8-9/10. It has been going on for the last 10 days and the only associated signs and symptoms are decreased exercise tolerance and some dry cough.

REVIEW OF SYSTEMS: CONSTITUTIONAL: As noted above, no fever. Also denies change of weight. HEENT: He denies any blurry vision or discharge. He denies any earaches, runny nose, or sore throat. HEMATOLOGY: He denies any bleeding from any site. Denies unusual bruising. CARDIAC: he denies any chest pain or palpitations. RESPIRATORY: He is complaining of severe shortness of breath and dry cough. GI: He denies any abdominal pain, nausea, vomiting, diarrhea, constipation, melena, hematochezia. GENITOURINARY: He denies any burning micturition. DERMATOLOGICAL: He denies any jaundice or rash. NEUROLOGICAL: He denies any loss of consciousness, light-headedness, dizziness or any weakness on any one side. PSYCHIATRIC: He denies feeling depressed or anxious.

PAST MEDICAL HISTORY:
2. Post radiation hypothyroidism.
3. Gastroesophageal reflux disease, hiatal hernia with subsequent stricture formation requiring repeated balloon dilation of the esophagus.
4. Possible Gilbert’s syndrome.
5. Relative lymphocytosis persistent since chemotherapy.
6. Hemorrhoids.

PAST SURGICAL HISTORY:
1. Neck/groin lymph node biopsy.
2. Exploratory laparotomy with splenectomy in 1983.
4. Multiple esophagogastroduodenoscopies with esophageal balloon dilations. The last esophagogastroduodenoscopy was in 2002.

CURRENT MEDICATIONS: Synthroid 75 mcg qam, Prilosec 20 mg qam, Anusol HC cream prn.
ALLERGIES: No known drug allergies.

SOCIAL HISTORY: He denies any history of smoking, alcohol, or drug abuse. He is single and has no children.

FAMILY HISTORY: His mother had hypertension, hyperlipidemia, and multiple ventral hernias.


RADIOLOGY STUDIES: Chest x-ray shows complete whitening of the left lung field. CT Scan of the chest shows complete fluid accumulation on the left side with complete collapse of the left lung. It also shows some lymphadenopathy.

PHYSICAL EXAMINATION:
VITAL SIGNS: blood pressure 120/88, pulse 104 regular, respirations 18, temperature 97.7, weight 168.4 pounds, oxygen saturation 98% on room air.
GENERAL: He is alert, awake, in mild to moderate respiratory distress at this time. EYES: Pink conjunctiva, anicteric sclera. Pupils are equal, round, and reactive to light. Extraocular movements are intact. NECK/LYMPH: Neck is supple. No jugular venous distention or cervical lymphadenopathy. LUNGS: He has absent breath sounds on the left side. Good air entry on the right side. No wheeze or rhonchi. HEART: Regular rate and rhythm. Tachycardia. Normal S1 and S2. No murmurs. ABDOMEN: Soft, non-tender, nondistended. No hepatosplenomegaly. Normoactive bowel sounds. MUSCULOSKELETAL: No CVA tenderness. EXTREMITIES: No cyanosis, clubbing or edema. Good distal pulses. NEUROLOGICALLY: There is no evidence of any focal neurological deficits. PSYCHOLOGICALLY: Alert and oriented times three.

ASSESSMENT:
1. Huge left sided pleural effusion with shortness of breath.
4. Post radiation hypothyroidism.
5. Hemorrhoids.

PLAN: The patient was sent directly from the office to radiology to get a chest x-ray. I reviewed the chest x-ray showing there is a complete opacification of the left lung, subsequently we immediately got a CT scan of the chest which showed complete collapse of the left lung and the left side is full of fluid. It also showed some lymphadenopathy. At that time, the decision was made to admit the patient as a direct admit. He was sent to the third floor. We will start oxygen 2 liters nasal cannula. We will have Dr. Green on consult for a left sided thoracocentesis. We will give him a regular diet. IV Heplock. Synthroid 75 mcg qam, Prilosec 20 mg qam. We will repeat a complete blood count and basic metabolic profile tomorrow morning. All of the above findings and plan were discussed with the patient. He seems to understand and agree. The patient has a guarded prognosis.

A. 99205
B. 99223
C. 99215
D. 99221
**Practice 3, Report B**

**LOCATION:** Inpatient, Hospital

**Discharge Summary**

**FINAL DIAGNOSIS:**
1. Acute gastrointestinal bleed with anemia, stable.
2. Coronary artery disease/stents/angioplasty.
3. Severe peripheral vascular disease.
4. Moderate to severe chronic obstructive pulmonary disease.

**HOSPITAL COURSE:** He is a 63-year-old white male with a known history of native coronary artery disease, status post PTCA with stents, peripheral vascular disease, chronic obstructive pulmonary disease who was admitted to the general medical floor on the 5th of August as a direct admit because of persistently low hemoglobin level and persistent melena. An esophagastroduodenoscopy was performed yesterday, which did not show any source of active bleeding. He was transfused two units of packed red blood cells and his hemoglobin has been stable around 11.4. He denies any complaints and wishes to go home.

**DISCHARGE MEDICATIONS:** He has been instructed to resume all his home medications as before.

**PLAN:** He is scheduled for a colonoscopy as an outpatient with Dr. Blue on the 9th of August at 6:30 AM. All instructions and the preparatory material have been given to the patient. If his colonoscopy does not show any source of bleeding we will get a capsule endoscopy done. We will get a hemoglobin level one day prior to his visit. He is scheduled for a follow-up visit with me in the office in one week.

**Codes:**
4. CONSULTATIONS (99241-99255)

Requesting physician or other appropriate source is the one asking for opinion/advice of another physician.

Physician who gives the opinion/advice is consultant.

Consultation codes reflect inquiries between physicians or other qualified personnel.

Written or verbal request for consultation must be documented in medical record.

Consulting physician must provide requesting physician documentation of:
- Examination
- Clinical judgment(s)
- Treatment(s) prescribed/recommended

Consulting physician is authorized to order all medically necessary tests/services to render an opinion.

According to CPT and CMS, only one consultation code should be reported per inpatient stay/per consultant.

Same physician may be consulted more than once regarding same patient provided there is documentation in the medical record indicating a change in patient’s status to support another consultation or a new condition in office setting.

This varies by payer.

Requires 3 of 3 key components be met.

Types of consultations:

Office or other outpatient consultations
- Applies to both new and established patients.
- Reflects consultations occurring in one of the following sites:
  - Physician office
  - Hospital observation services
  - Home services
  - Nursing facility
  - Rest home or custodial care
  - Emergency department
  - Any other ambulatory facility

Inpatient consultation
- Reported for both new and established patients, no separate designation.
- Documentation on all three key components must either be met or exceeded.
- Limited to one initial inpatient consultation per patient/hospitalization by a consultant.
PRACTICE 4. CONSULTATIONS

Once you have coded the two cases, check your answers in the answer key at the end of this PDF, where you will locate the answers and rationales.

Practice 4, Report A

LOCATION: Outpatient, Office

Dear Dr. Green:

Thank you for asking me to evaluate Ms. N., a 50-year-old female, for fever, rash, and mouth sores occurring after a trip.

The patient and her husband tell me that they traveled to Hawaii in November. They flew into San Diego and took a bus to the ship in Ensenada, Mexico. The cruise ship then went to the islands of Hawaii. While in Hawaii, they took tours by bus to volcanoes. She did shopping in the towns they stopped in. The patient did no swimming while there and had no fresh water exposure. She was not around any animals. There were no ill contacts on the cruise ship. She did not eat any food while in Mexico, but did drink bottled water.

The patient and her husband returned to town on December 6. The patient notes that 2 weeks ago she began feeling fatigued and “not good.” Twelve days ago she developed a fever to 103.8, as well as “sores” along the side of her tongue and her throat. Since then, she notes that she has developed both gingival and buccal lesions. She did have severe odynophagia and reports trouble drinking water. She denies any lesions on her lips.

Eight days ago, due to ongoing oral pain as well as pain that had developed in the neck and on the right side of her face and ear, she was seen as an outpatient. She tells me that she was given Prednisone because of oral swelling. She does not know the dosage of her Prednisone, but states that it was given for 5 days.

Six to seven days ago, the patient developed a cough. She tells me that this was nonproductive until this morning, when she began having “phlegmy, yucky stuff.” She had a chest x-ray done three days ago and tells me that it was “free of pneumonia.”

Three to four days ago, the patient began developing lesions on her neck and scalp. They are non pruritic, but are associated with sharp “nerve pain” which the patient describes as “intense.”

The patient’s fevers have decreased since her initial illness. She tells me that she is still having maximum temperatures of 101, and is taking Advil and Tylenol around the clock.

Past medical history is well known to you, and will not be reiterated here. Social history includes that the patient is married. She has three dogs and three cats, all of which are full grown. The cats are declawed on all four paws. She has had no nips or bites. The patient does not work outside the home. She was taking care of her 18-month-old granddaughter 2 days per week, up until the time that the patient became ill. The patient notes that the granddaughter has not been ill throughout this time.

On physical examination in my clinic, temperature was 99.0. Her pulse was 78 and her blood pressure was 118/86. Her weight was 168 pounds (decreased 15 pounds from October). The exam was significant only for skin, head, and neck exam. The mouth had multiple small punctate ulcers, all of which were on a white base. These were all between 1 and 3 mm and were on the buccal mucosa and in the oropharynx. There were labial lesions and no palatal lesions. There was mild anterior cervical lymphadenopathy, which was mildly to moderately tender. This all measured less than 2 cm and there was no associated
erythema or fluctuance. Skin exam revealed several small pustular lesions located on the scalp and neck.

I suspect that the patient has a Coxsackie virus infection with predominance of oral lesions. With no exposure to animals or fresh water while in Hawaii, more unusual infections such as Leptospirosis would be exceedingly unusual. Additionally, her symptom complex (and particularly her oral ulcers) is not suggestive of either Typhus or Leptospirosis. Also in the differential diagnosis would be an adverse drug reaction to her chronic Augmentin. The patient was due to complete this in one week with a planned total duration of Augmentin of 6 months. I recommended that the patient stop her Augmentin 1 week early. I think that it would safe to re-challenge her with Augmentin into the future, if she required antibiotics. However, if she redeveloped oral ulcers with re-challenge of Augmentin, she would then need to be labeled as allergic to Augmentin.

Follow up will be on an as-needed basis in our clinic.

A. 99243
B. 99244
C. 99203
D. 99215

Practice 4, Report B, DOS – 5/20/XX

LOCATION: Inpatient, Hospital

CONSULT REQUESTED BY: Dr. Sutter, attending physician

REASON FOR CONSULTATION: Nausea, vomiting, and abdominal pain.

HISTORY OF PRESENT ILLNESS: The patient is a 33-year-old woman with a past medical history of diabetes, diabetic gastroparesis, status post J-tube placement in 2004, who now presents with an approximately 2-day history of nausea and vomiting. According to old records, the patient had been made n.p.o. with strict J-tube feedings; however, the patient has been noncompliant with this therapy and admits to taking moderate p.o. intake. The patient also complains of diffuse abdominal pain that does not radiate. The patient states that she has had this pain in the past. It is not specific and is not localized to any one point. The patient denies any chest pain, shortness of breath, fevers, or chills. She denies any change in her bowel movements. She states that she has been somewhat more constipated lately with her last formed bowel movement approximately 1 day prior. The patient states that she had diarrhea this morning. She denies any hematochezia or melena. She denies any dysuria or symptoms related to gastroesophageal reflux disease.

PAST MEDICAL HISTORY:
1. Diabetes, Type II.
2. Hypertension.
3. Diabetic gastroparesis.

PAST SURGICAL HISTORY:
1. Cholecystectomy.
2. Tubal ligation.

MEDICATIONS: Duragesic patch, Diflucan, insulin, Prevacid, Phenergan, Reglan, lisinopril, Lexapro, methadone.
ALLERGIES: No known medical allergies.

SOCIAL/FAMILY HISTORY: The patient does not smoke or drink alcohol. No family history of GI problems.

REVIEW OF SYSTEMS: The patient has a detailed review of systems per history and physical examination of 3 days prior to admission to hospital (5/17/XX).

PHYSICAL EXAMINATION:
GENERAL: The patient is a 33-year-old woman who appears older than her stated age. She is in no acute distress. She closes her eyes easily during questioning and responds only to repeated questions. VITAL SIGNS: Temperature 97.4 degrees, heart rate 91, blood pressure 106/57, oxygen saturation 97% on room air. HEENT: Pupils equal, round, reactive to light and accommodation and extraocular motions intact. Sclerae are anicteric. Oropharynx is benign. Mucous membranes are dry. NECK: Soft, supple, and nontender. No masses were felt.

LUNGS: Clear to auscultation, bilaterally. There are no rhonchi, rales, or wheezes. The patient is not in respiratory distress. HEART: Regular rate and rhythm, normal S1 and S2, no S3, murmurs, or rubs heard. ABDOMEN: Shows a well-healing midline scar, as well a J-tube. Abdomen is soft and slightly distended. There is no focal tenderness. There are hypoactive bowel sounds. There is no guarding, hepatosplenomegaly, or masses felt. The patient does not have any growing hernias. EXTREMITIES: Non-tender without edema.

NEUROLOGIC: The patient is intact.

LABORATORY STUDIES: Electrolytes are within normal limits. Alkaline phosphatase is 119, ALT 583, AST 679, bilirubin 0.4, albumin 2.8, white blood count 6.6, and hemoglobin 12.1.

RADIOLOGY STUDIES: Upright abdominal x-ray showed minimal distention of the small bowel. There were some small associated air fluid levels. There is a small amount of gas and stool in the colon. There are no signs of free air or free fluid. CT scan of abdomen and pelvis is pending at this time.

IMPRESSION/RECOMMENDATIONS: The patient is a 33-year-old woman with a history of diabetic gastroparesis who presents now with nausea, vomiting, and abdominal pain.

1. These symptoms could represent diabetic gastroparesis. The patient will need a nasogastric tube placed. We will keep the patient n.p.o., as well as hold her J-tube feeding for now. We will review the CT scan findings with the radiologist. Otherwise, we will continue to treat this conservatively with intravenous fluids. In addition to her past medical history, the patient is on methadone, as well as Duragesic patch, which could cause significant ileus. The patient may need further small bowel imaging if the CT scan is inconclusive and her symptoms persist. However, the CT scan is a good modality for evaluating partial small-bowel obstructions.

2. Elevated transaminase. The patient was admitted with normal ALT and AST; however, on admission the patient developed AST and ALT elevations. This could be due to multiple causes; however, drug induced is likely given that the patient was started on Diflucan and Zosyn, both with known hepatic toxicity profiles. We will defer changing these antibiotics per the primary service. Bilirubin is within normal limits and the patient is not clinically jaundice or complaining of any upper quadrant pain suggestive of biliary obstruction. We will discuss this case with the general surgeon who is on call for general surgery today.

Codes:
5. EMERGENCY DEPARTMENT SERVICES (99281-99288)

   ED services may also be billed by physicians who are not assigned to the ED
   No distinction is made between new and established patients
   Requires 3 of 3 key components be met
   No “time” component
   Any physician who provides services in the ED may use these codes to report
   the service
   If the physician asks the patient to meet him/her in ED as an alternative to the
   physician’s office and the patient is not registered as an ED patient
   Report the service with appropriate office/outpatient visit codes (99201-99215)
   Facilities qualifying as EDs must be
     Open and available 24 hours a day
     Located in organized hospital-based facility
     Exist to provide immediate medical attention to persons without the
     constraints of prior scheduled appointments
   Code assignment determined by severity of patient’s condition as reported by
   physician in medical record and complexity of medical decision making
   Facilities may use acuity sheet “as guidance,” such as that in Figure 1-9 to assign
   level of ED service
<table>
<thead>
<tr>
<th>Level 1—99281</th>
<th>Level 2—99282</th>
<th>Level 3—99283</th>
</tr>
</thead>
</table>
| 1. Initial (triage) assessment  
2. Suture removal  
3. Wound recheck  
4. Note for work or school  
5. Simple discharge information | Interventions from previous level plus any of the following:  
1. OTC med administration  
2. Tetanus booster  
3. Bedside diagnostic tests (stool hemoccult, glucometer)  
4. Visual acuity  
5. Orthostatic vital signs  
6. Simple trauma not requiring x-ray  
7. Simple discharge information | Interventions from previous level plus any of the following:  
1. Heparin/saline lock  
2. Crystalloid IV therapy  
3. X-ray, one area  
4. RX med administration  
5. Fluorescein stain  
6. Quick cath  
7. Foley cath  
8. Receipt of ambulance patient  
9. Mental health emergencies (mild) not requiring parenteral medications or admission  
10. Moderate complexity discharge instructions  
11. Intermediate layered and complex laceration repair |

<table>
<thead>
<tr>
<th>Level 4—99284</th>
<th>Level 5—99285</th>
<th>Critical Care 99291, 99292</th>
</tr>
</thead>
</table>
| Interventions from previous level plus any of the following:  
1. X-ray, multiple areas  
2. Special imaging studies (CT, MRI, ultrasound)  
3. Cardiac monitoring  
4. Multiple reassessments of patient  
5. Parenteral\(^{1}\) medications (including insulin)  
6. Nebulizer treatment (1 or 2)  
7. NG placement  
8. Pelvic exam  
9. Mental health emergencies (moderate). May require parenteral medications but not admission  
10. Administration of IV medications | Interventions from previous level plus any of the following:  
1. Monitor/stabilize patient during in hospital transport and/or testing (CT, MRI, ultrasound)  
2. Vasoactive medication  
3. Administration (dopamine, dobutamine, multiple) nebulizer treatments (3 or more)  
4. Conscious sedation  
5. Lumbar puncture  
6. Thoracentesis  
7. Sexual assault exam  
8. Admission to hospital  
9. Mental health emergency (severe) psychotic and/or agitated/combative  
10. Requires admission  
11. Fracture/dislocation reduction  
12. Suicide precautions  
13. Gastric lavage  
14. Complex discharge instructions | Interventions from any previous level plus any of the following:  
1. Multiple parenteral medications  
2. Continuous monitoring  
3. Major trauma care  
4. Chest tube insertion  
5. CPR  
6. Defibrillation/cardioversion  
7. Delivery of baby  
8. Control of major hemorrhage  
9. Administration of blood or blood products |

\(^{1}\)not through the alimentary canal but rather by injection through some other route, such as subcutaneous, intramuscular, intraorbital, intracapsular, intraspinal, intrasternal, or intravenous

Figure 1–9. Example of an acuity sheet used as a guiding tool to determine level of emergency department services.
PRACTICE 5, EMERGENCY DEPARTMENT SERVICES

Using the acuity sheet (Figure 1–9), code the following two cases and then check your answers in the answer key at the end of this PDF, where you will locate the answer and written rationales.

Practice 5, Report A

CHIEF COMPLAINT: Abdominal pain.

HISTORY OF PRESENT ILLNESS
This is a 34-year-old female who presents to the ED and has had upper abdominal pain, nausea, and diarrhea today not associated with fevers, pain with urination, urgency, or frequency. The patient had similar problems about a month ago, and that workup was negative. It is not associated with food, melena, hematochezia, and no sick contacts that she is aware of.

PAST MEDICAL HISTORY: Asthma, hypertension, depression, migraines, esophageal reflux, and arthritis.

MEDICATIONS/ALLERGIES: (Reviewed. See nursing notes, on Lisinopril for HTN.)

PAST SURGICAL HISTORY: She has had a tubal ligation.

FAMILY HISTORY: Unremarkable for present condition, but a history of hypertension.

SOCIAL HISTORY: Denies alcohol, drug, or tobacco use.

REVIEW OF SYSTEMS: Positive for abdominal pain, nausea, and diarrhea. Remainder of 10-point review of system performed is negative.

PHYSICAL EXAMINATION
General—the patient is a 34-year-old female who does not appear toxic or in distress. Vital signs—she has stable vitals blood pressure 140/84 and afebrile. HEENT—nonicteric sclerae. Oropharynx does not appear significantly dry. Neck—supple. Lungs—clear. Heart—regular rate and rhythm without murmur. Abdomen—she has some diffuse upper abdominal pain, but no peritoneal signs nor flank discomfort. Skin—exam is unremarkable. Neurological—she is awake, alert, appropriate, and ambulates normally.

EMERGENCY DEPARTMENT COURSE
The patient was given pain medication and IV fluids. She had an ultrasound performed 1 month ago and was essentially negative. All her lab work was normal. Her pain was controlled. I felt she probably was coming down with some type of viral syndrome.

PROVISIONAL DIAGNOSIS/DIAGNOSES: Evaluation of upper abdominal pain, etiology undetermined.

PLAN(S)
1. The patient was given abdominal pain instruction sheet.
2. Sent home with a prescription for Bentyl.
3. I recommend that she follow up with her primary care physician if she has persistent problems.
   Condition at discharge was stable.

A. 99284; 789.09, 787.02, 787.91, 401.9
B. 99285; 789.00, 079.9, 401.9
C. 99283; 789.00, 401.9
D. 99284; 789.09, 079.99, 401.9
**Practice 5, Report B**

**CHIEF COMPLAINT:** Ankle injury.

**HISTORY OF PRESENT ILLNESS**
The patient is a 16-year-old male who was skateboarding today and had an inversion injury of his left ankle. He is ambulatory but complains of pain and swelling. No other complaints or injuries at this time. See nurse’s notes for medications and allergies.

**ROS**
Patient states no dizziness prior to or after the fall. No recent muscle or joint problems. No broken skin.

**HISTORY**
No past surgeries. The patient is a junior in school and does play sports.

**PHYSICAL EXAMINATION**
Height 68”, weight 185, BP 120/58. He is an alert and pleasant male in no acute distress. Examination of the left lower extremity shows a soft tissue swelling of the lateral malleolus. He has no base of the 5th metatarsal tenderness. He has no proximal tibial tenderness. Neurovascularly intact distally.

**EMERGENCY DEPARTMENT COURSE**
Plain films were performed and showed no evidence of acute fracture or malalignment and told this represented sprain. I recommend symptomatic care, air cast, ice, crutches, and Motrin. Follow up with primary care physician. Return for any problems. He is agreeable to this plan. He was discharged home in stable condition.

**PROVISIONAL DIAGNOSIS/DIAGNOSES:** Left ankle sprain.

Codes:
6. CRITICAL CARE SERVICES (99291, 99292)

Critical care is provided when

Used for outpatient (ED or office) neonates and pediatric patients up to 71 months

Used for outpatient and inpatient services for patients over 71 months

For infants or young children ages 2 through 5 years receiving inpatient critical care use the pediatric critical care codes (99475, 99476)

For infants 29 days through 24 months receiving inpatient critical care use the pediatric critical care codes (99471, 99472)

For infants 28 days or younger use neonatal inpatient critical care codes (99468, 99469)

One or more of the vital organ(s) is in/has high probability for being in a life-threatening state

A high complexity of MDM is required for treating vital organ(s) failure and/or prevention of further deterioration in the patient’s condition

Examples of vital organ failure

- Central nervous system
- Circulatory failure
- Presence of shock
- Renal failure
- Hepatic failure
- Metabolic failure
- Respiratory failure

Threats to vital organs are not limited to the above list

Most (but not all) critical care involves an interpretation of either advanced technology and/or multiple interpretations with physiologic parameters

Codes may also be assigned for critical care services for

- Postoperative patient
- Patient with a deteriorating condition

Type of physician time and location is an important key in assigning these codes

Time spent on critical care may include time

- On medical unit reviewing patient care with or without other medical staff
- Spent documenting patient’s status into medical record
- Spent with the patient’s family or caregivers compiling a history and/or discussing medical management if patient is clinically incompetent

Time spent in a face-to-face encounter may be accumulated over course of day

Example: Three 30-minute encounters result in 90 minutes of time

Time spent must be documented in the medical record
PRACTICE 6, CRITICAL CARE SERVICES

These are time-based codes, so no audit form is required. Once you have coded the two cases, check your answers in the answer key at the end of this PDF, where you will locate the answers and rationales.

Practice 6, Report A

CHIEF COMPLAINT: Syncope, neck pain.

HISTORY OF PRESENT ILLNESS
An 88-year-old male who presents to the ED after he apparently had a syncopal episode at home. Unfortunately, the patient does not remember the episode. He was found by his wife, he was able to stand on his own. He complained of some neck pain and was placed on a backboard and transported via EMS. The patient does not remember walking around the house this morning and does not know what he was feeling, does not remember if he had any symptoms prior to the collapse. Vital signs documented per supplemental sheet. I do not believe the patient is a reliable historian.
Per the family, he has had a history of cancer, COPD, atrial fibrillation.

PSH: Left carotid endarterectomy and a Nissen. The patient quit smoking 40 years ago.

FH: Positive for coronary disease.

MEDICATIONS/ALLERGIES: A full 10-point review of systems is otherwise negative. (Some Medicare carriers require systems to be noted)

PHYSICAL EXAMINATION
The patient was afebrile, vital signs notable for a pulse of 116, otherwise normal. In general, a pleasant male on a backboard, wearing a C-collar, in no acute distress. HEENT: Pupils equal, round and reactive, extraocular movements intact. There are no signs of trauma about the face or scalp. Neck is examined with in-line stabilization, in a C-collar. The patient had some tenderness over the upper cervical spine and was kept in a C-collar. CV tachy and irregular but no murmur. Lungs are clear. Abdomen is soft, nontender. Extremities unremarkable with no rash, no focal tenderness. Back exam revealed no tenderness. Neurologically the patient was oriented to person and place.

EMERGENCY DEPARTMENT COURSE
The patient was carefully log-rolled off the backboard. Did have an EKG which showed atrial fibrillation with some lateral ST depression consistent with digitalis effect. Patient did have a metabolic panel which showed the glucose of 114, otherwise normal. CBC showed a white count of 10.9, hemoglobin 12.1. Troponin 0.04, myoglobin 611, thought to be elevated secondary to his syncope. Urinalysis was negative. CT of the head was unremarkable except for possible left basal ganglia lacunar infarct. CT of the C-spine did show fracture of the C4 left pedicle and left transverse foramina. With this finding, the patient was kept in a C-collar, was seen by orthopedics. Discussed with primary care physician. The patient will be admitted in guarded condition.

PROVISIONAL DIAGNOSIS/DIAGNOSES
2. Syncope of uncertain cause.
The patient is neurologically intact. Total critical care time did exceed 30 minutes.
A. 99291; 806.00, 780.09
B. 99221; 99291, 805.04, 780.2
C. 99291; 805.04, 780.2
D. 99221; 99291, 806.00, 780.2

Practice 6, Report B

CHIEF COMPLAINT: Altered level of mental status.

HISTORY OF PRESENT ILLNESS
This is an 84-year-old male who was found by his son to be somewhat unresponsive and seeming to have difficulty with gasping for air. This was at his group home where he is in assisted living. The son had the staff check an oxygen level and it was 70%, so EMS was called and the patient was brought here. The patient has responded to verbal stimuli, but has not indicated any pain. The son is not aware of any fever or vomiting, although the patient has not been eating well for the last week or so. PAST MEDICAL HISTORY: There is a history of bladder cancer. There is also a history of pulmonary embolism and deep venous thrombosis and the patient is on Coumadin. He has also had a history of stroke. SOCIAL HISTORY: The patient is here with his son. There is a “do not resuscitate order” within his advance directive that indicates he does not want intubation or CPR according to the son. The son does want to see the patient get necessary medication or fluids. As noted above, he lives in assisted living. ROS: I was not able to do a review of systems on the patient because of his lethargy. The son stated he did not know of any recent fever or cough. He did not know of any vomiting or urinary difficulties.

PHYSICAL EXAMINATION
Vital signs show a low blood pressure of 89/48 with a normal pulse of 90 and regular. Increased respiratory rate of 28, but not labored. Now that the patient is on oxygen he is not using accessory muscles respiration or gasping. The pharynx shows no inflammation or exudate, but is very dry. There is no cervical adenopathy and his neck is supple. Pupils equal, round, and reactive to light. Cranial nerves II-XII are intact. The patient is able to cooperate enough to squeeze my fingers or to lift his arms and legs, and he does this in a symmetrical way in all 4 extremities. The heart has normal S1-S2 without murmur. Lungs are clear to auscultation and percussion. The abdomen is soft and nontender throughout without mass, guarding or rebound tenderness. Lower extremities show no swelling, tenderness, or cords. Skin is clear of significant rashes.

DIAGNOSTIC STUDIES
LABORATORY/PATHOLOGY: Pulse oximetry is adequate at 96% on an oxygen mask by nonrebreather. CBC shows low hemoglobin of 11.1 and elevated white count of 14,300. Electrolytes shows high potassium of 5.1, high chloride of 114 and low CO2 of 19. BUN is high at 50 and creatinine high at 3.3. These are significant elevations since a previous level done 8 days ago when he had a BUN of 17 and creatinine of 1.3. Glucose is high at 154, albumin is low at 2.7. Liver studies are basically normal. Urinalysis is positive for probable infection with 11 white cells and small leukocyte esterase. Troponin I is normal at less than 0.03.

IMAGING: Chest x-ray shows no active infiltrate.
**EKG:** A 12-lead electrocardiogram was done for the indication of lethargy and hypotension, and the computer interpretation was reviewed. The tracing shows normal sinus rhythm with frequent premature atrial contractions. There is nonspecific T-wave flattening present in the inferior and lateral leads. There are Q waves in leads III and aVF consistent with old inferior MI. There are no acute ischemic changes.

**EMERGENCY DEPARTMENT COURSE**
I gave the patient a liter of IV fluids in the emergency department over a couple of hours and this with the oxygen resulted in definite improvement of his mental status. He was alert and easily responsive after the first 700 mL of saline. I ordered Levaquin 250 mg IV. I spoke with his primary physician and he is going to come over to the emergency department and admit the patient.

**PROVISIONAL DIAGNOSIS/DIAGNOSES**
1. Altered mental status.
2. Upper respiratory infection.
3. Urosepsis (UTI).
5. Low blood pressure reading, which has now improved.
6. History of anticoagulation for pulmonary embolism and deep venous thrombosis.
Will continue to monitor therapeutic levels.

**DISPOSITION**
He was admitted as noted. Condition on discharge from the emergency department is improved. Critical care time was 30 minutes on this patient.

**Codes:**
7. NURSING FACILITY SERVICES (99304-99318)

These codes are used for patients in
- Nursing facilities
- Intermediate care facilities
- Long-term care facilities
- Psychiatric residential treatment centers

Psychiatric residential treatment centers are those that
- Provide a 24-hour therapeutically planned living and/or learning environment
- With professionally trained staff

Medical psychotherapy is not included in codes

There are four subcategories of codes in nursing facility codes
- Dependent on assessment instruments used by the nursing facility to assess a resident’s functional capacity
  - Initial Nursing Facility Care
  - Subsequent Nursing Facility Care
  - Nursing Facility Discharge Services
  - Other Nursing Facility Services (Annual Assessments)

Two forms are used to determine the patient’s status
- Resident Assessment Protocols (RAP)
- Residential Assessment Instrument (RAI) with uniform Minimum Data Set (MDS)

Uniform minimum data (MDS) for nursing facilities must include or exceed following information
- Medically defined conditions and prior medical history
- Medical status measurement
- Physical and mental functional status
- Discharge potential
- Dental condition
- Activities potential
- Rehabilitation potential
- Cognitive status
- Drug therapy

MDS must contain input from physician for evaluation and formulation of multidisciplinary care
- When an MDS appears incomplete or signals a need for supplementary information, Resident Assessment Protocols (RAPs) are used

RAP must be used by nursing facility in following situations
- At time of patient admittance to facility
- When 12 months have lapsed since previous assessment
- When a major permanent change in patient’s status is observed
RAP is helpful in assessing potential problems and provides useful information for follow-up procedures.

When a patient is admitted to a nursing care facility from another medical service site, such as a physician office or an emergency department, all services performed on date of admission are evaluated (considered) as part of initial facility care codes.

Discharge day code is used when either a discharge from a hospital or observation status in a hospital occurs on same date as admission to a nursing facility, code also the nursing home admission.

Note: When a physician discharges a patient from a nursing facility, the appropriate code is based on the time spent with the patient and/or family and/or caregiver discussing both the facility stay and management options, which the physician bases on his/her final examination.
PRACTICE 7, NURSING FACILITY SERVICES

Once you have coded the two cases, check your answers in the answer key at the end of this PDF.

Practice 7, Report A

LOCATION: Light Hills Nursing Home, established patient
Emily is seen for a review of chronic controlled conditions listed below. The chart is reviewed along with the nursing notes. Advanced directives are in place.

S: No fevers or chills. No chest pain or shortness of breath.

O: This well-developed, well-nourished lady is sitting without distress. HEENT is normal, normocephalic, and atraumatic. Neck is supple. Lungs clear to auscultation.

A: 1. Chronic headaches
   2. Bipolar disorder
   3. Hypertension, primary
   4. Tardive dyskinesia secondary to antidepressants
   5. Urinary incontinence

P: 1. The patient has chronic headaches for which she has been taking Fioricet as needed, but I will go ahead and start her on Topamax for preventative measures, 25 mg one p.o. H.S. for 10 days and then one p.o. bid for 10 days and then one in the AM and two at H.S. for 10 days. Then we will start 50 mg p.o. bid.
   2. Reassess in 4 weeks.
   3. In the meantime, the case was discussed with the charge nurse and I advised that the Topamax may cause a little increased fatigue and hypersomnolence but if it is clinically significant, we might have to decrease the doses.

A. 99309; 784.0, 296.90, 401.9, 333.82, 788.30, E939.3
B. 99308; 784.0, 296.80, 401.9, 333.82, 788.30, E939.3
C. 99336; 784.0, 296.90, 401.9, 969.3, 788.30, E939.3
D. 99309; 784.0, 296.80, 401.1, 333.85, 788.30, E939.3

Practice 7, Report B

LOCATION:
Nursing Facility

This patient is seen for a routine visit for chronic conditions. No code in place. The chart is reviewed along with the nursing notes. Advanced directives are in place. The graphic chart is also reviewed.

S: No fevers or chills. No chest pain or shortness of breath. Nurse states patient continues to be frequently combative and wanders off.

O: This well-developed, well-nourished gentleman is sitting without distress. HEENT - normocephalic and atraumatic. Neck is supple. Lungs - clear to auscultation.

A: 1. Alzheimer dementia
   2. Dementia and combative behavior.

P: 1. As the patient is otherwise clinically stable; the rest of the treatment is without change.

Codes:
8. DOMICILIARY, REST HOME (E.G., BOARDING HOME), OR CUSTODIAL CARE SERVICES, AND DOMICILIARY, REST HOME (E.G., ASSISTED LIVING FACILITY), OR HOME CARE PLAN OVERSIGHT SERVICES (99324-99340)

**Domiciliary, Rest Home (e.g., Boarding Home), or Custodial Care Services (99324-99337)**

These codes are used to report services in two settings

- Facility providing room, board, and other personal assistance services on a long-term basis
- Assisted living facility without a medical component

Code choice based on whether patient is new or established patient

- For a new patient all 3 key components must be met or exceeded
- For an established patient, 2 of 3 key components must be met or exceeded

Time spent by a physician is considered a contributory factor when assigning a code for service

**Domiciliary, Rest Home (e.g., Assisted Living Facility), or Home Care Plan Oversight Services (99339-99340)**

Reports physician supervision of patient, when patient is not present

Patient resides in

- Own home
- Rest home or domiciliary
  - Includes assisted living facility

Codes based on time spent during calendar month

Not for patients receiving

- Home health care (99374-99375)
- Hospice care (99377-99378)
- Nursing facility services (99379-99380)

Physician provides the following types of services

- Reviews subsequent reports, laboratory studies, or other studies
- Integrates new data into patient’s care plan
- Adjusts medical therapy
- Develops or revises care plans
- Communicates with other health care professionals
PRACTICE 8, DOMICILIARY, REST HOME (E.G., BOARDING HOME), OR CUSTODIAL CARE SERVICES, AND DOMICILIARY, REST HOME (E.G., ASSISTED LIVING FACILITY), OR HOME CARE PLAN OVERSIGHT SERVICES (99324-99340)

Once you have coded the two cases, check your answers in the answer key at the end of this PDF, where you will locate the answers and rationales.

Practice 8, Report A

LOCATION: Custodial Care Center, established patient

Patient evaluated today for a rash on her arms for the last 3 days. Nursing staff reports that lotion has been applied with no relief. Examined the patient and rash is contained to her arms. Staff also noticed that the patient has been sleeping a lot during the day. When I questioned the patient on her sleeping, she let me know that she has not been sleeping at night. Other than the rash and her sleeping habits, the patient is overall healthy.

Benadryl cream will be given prn for the patient’s rash. Watch to make sure it doesn’t spread. There is no change in her care plan at this time.

A. 99335; 782.1, 780.52
B. 99307; 782.1, 307.42
C. 99347; 782.1, 307.42
D. 99325; 782.1, 780.52

Practice 8, Report B

LOCATION: Shady Lane Rest Home

This is an 80-year-old man, who resides in a rest home, complaining of painful urination. The pain is 5 out of 10. He has a suprapubic catheter due to urinary retention. He has been treated for urinary tract infections in the past with Cipro. He is having acute abdominal pain and fever. He has been eating fair.

EXAMINATION: When I visit with him today, he denies any weight loss, SOB, or palpitations. He is mildly confused. He answers yes and no, but there is very little conversation. His color is pink. His HEART is regular without murmur. His CHEST is diminished breath sounds with mild crackles at both bases. ABDOMEN is soft and nontender with active bowel sounds. His EXTREMITIES show no edema.

PLAN: Medications and treatments have been reviewed. I will place the patient on Cipro to treat UTI. No other changes to care plan at this time.

Codes:
9. HOME SERVICES (99341-99350)

Reports interaction between a physician and either new or established patient within the patient’s residence

“Homebound” status required by many payers

New patient visit

  3 key components must be met or exceeded

Established patient visit

  2 of 3 key components must be met or exceeded
PRACTICE 9, HOME SERVICES

Once you have coded the two cases, check your answers in the answer key at the end of this PDF.

Practice 9, Report A

LOCATION: Patient’s Home, established patient

CHIEF COMPLAINT: Cough.

HISTORY OF PRESENT ILLNESS: This 89-year-old male, who is well known to me, has been coughing somewhat more as reported by the nurse and his wife over one week but he seems to be sleeping rather well, without having to be propped up for any possible paroxysmal nocturnal dyspnea. He does not awaken through the night with difficulty breathing. His appetite appears to be normal. He is otherwise not complaining of any abdominal discomforts, but notes ankle swelling.

EXAMINATION:
General: The patient is seen in his home. Vital signs are stable. He has some coughing and has more swallowing of his right leg than the left. He is mostly bed-bound but does get up and eat his meals but gets out sometimes with help.
HEENT: Head is normocephalic. Ears are clear bilaterally. Throat is slightly dry. Neck is supple. LUNGS: Lungs demonstrate rhonchi bilaterally. No wheezes are noted. HEART: Heart demonstrates a regular rate and rhythm with no murmur, click, or rub. ABDOMEN: Abdomen is protuberant. Benign with no masses or tenderness. GENITALIA: Normal, no swelling. RECTAL: Deferred. EXTREMITIES: Pitting edema localized bilaterally (LE), the right a little more than the left. He does have several decubiti (sacral, hip) which are currently being treated and appear to be healing and not getting worse.

IMPRESSION:
1. Bronchitis.
2. Severe osteoarthritis.
3. Multiple decubiti of sacrum and hip.
4. Pitting edema localized.

RECOMMENDATION:
He will be started on Zithromax Z-pak as directed.
He will continue his cough syrup, Robitussin AC 1 tsp 4 times a day.
Continue Lasix 40 mg a day.
Decrease salt intake. His wife is instructed to not add any salt at the table and to make sure that he does not eat any potato chips or obviously salty foods.

A. 99343; 491.0, 715.90, 782.3, 707.03, 707.04
B. 99343; 490, 715.90, 782.3, 707.00
C. 99349; 490, 715.90, 707.03, 782.3, 707.04
D. 99349; 491.0, 715.90, 707.00, 782.3

Practice 9, Report B

LOCATION: Patient’s Home

PATIENT: 91-year-old male

CC: Cough with underlying CHF
The 91-year-old gentleman is seen at home in bed. He has had more of a productive cough since Monday with no swelling of his ankles. He has been continuing on his usual medication including Tequin 400 mg once a day and Robitussin AC one teaspoon 4 times a day, with some relief. I have asked for his head to be elevated 30 degrees while he is in this respiratory condition. Today he is doing much better. He awakens every now and then. I believe he still recognizes me.

ROS was attempted but not obtained due to the patient’s condition. The patient does suffer from CHF and Parkinson’s, primary.


**IMPRESSION:**
1. CHF
2. Cough
3. Bronchitis
4. Osteoarthritis
5. Parkinson’s primary

**RECOMMENDATIONS**
Finish the antibiotics.
Continue to monitor.

Codes: ___________________________________________________________________________
10. PROLONGED SERVICES (99354-99360)

Under the Prolonged Services subsection there are three categories

Prolonged Physician Service With Direct (Face-to-Face) Patient Contact (99354-99357)

Prolonged Physician Service Without Direct (Face-to-Face) Patient Contact (99358, 99359)

Physician Standby Services (99360)

Prolonged Physician Service With or Without (Face-to-Face) Patient Contact

Codes 99354-99359 are all add-on codes

Only assigned when estimated service exceeds the time listed by more than 30 minutes

First 30 minutes of prolonged services are not reported but are considered part of initial service

Used in addition to codes reported for other E/M services

Used in addition to other codes to show an extension of the service

Unusual length of service may be in inpatient or outpatient setting

Codes available for services with or without face-to-face provider and patient contact
### PRACTICE 10A, PROLONGED SERVICES WITH OR WITHOUT DIRECT PATIENT CONTACT (99354-99359)

*These are time-based codes; therefore, no audit form is required. Once you have coded the two cases, check your answers in the answer key at the end of this PDF.*

**Practice 10A, Report A**

**LOCATION:** Outpatient Clinic

<table>
<thead>
<tr>
<th>Chief Complaint:</th>
<th>Chronic Renal Failure, Diabetes Mellitus and Hypertension</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hx of Present Illness:</td>
<td>The patient presents to the clinic today for a follow-up appointment for hypertension and chronic kidney disease. At her last visit the Norvasc was increased to 5 mg PO QD. She has been seeing a cardiologist and pulmonologist for breathing problems. The Labetalol was discontinued and she was started on Toprol XL 50 mg PO QD. She was also started on an Advair inhaler b.i.d. by the pulmonologist. Her breathing has been much better. Her BP has been higher running 150’s systolic at home. She has been feeling relatively well. She does have a history of renal artery stenosis with right renal artery stent placement. Labs today include: BUN 26, sodium 140, creatinine is better at 1.2 mg/dL, CO2 28.6, K+ 4.5.</td>
</tr>
<tr>
<td>Urinary Symptoms:</td>
<td>Patient has no urinary symptoms.</td>
</tr>
<tr>
<td>Uremic Symptoms:</td>
<td>Patient has no uremic symptoms.</td>
</tr>
<tr>
<td>Cardiovascular Symptoms:</td>
<td>Patient has no cardiovascular symptoms.</td>
</tr>
<tr>
<td>PAST MEDICAL HISTORY:</td>
<td>Hypertension&lt;br&gt;Proteinuria&lt;br&gt;Atrial Fibrillation&lt;br&gt;Osteoarthritis in LT knee&lt;br&gt;Coronary Artery Disease&lt;br&gt;Cataract surgery&lt;br&gt;Open cholecystectomy</td>
</tr>
<tr>
<td>SOCIAL HISTORY:</td>
<td>Marital Status:&lt;br&gt;Current Occupation:&lt;br&gt;Past Occupation:&lt;br&gt;Current Alcohol use: No&lt;br&gt;Current Smoker: No&lt;br&gt;Ex-Smoker: No&lt;br&gt;Residence:</td>
</tr>
</tbody>
</table>
### REVIEW OF SYSTEMS:

<table>
<thead>
<tr>
<th>System</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constitutional</td>
<td>Negative</td>
</tr>
<tr>
<td>Eyes</td>
<td>Wear glasses</td>
</tr>
<tr>
<td>ENT</td>
<td>Negative</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>Mentioned in HPI</td>
</tr>
<tr>
<td>Respiratory</td>
<td>Dry cough</td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>Negative</td>
</tr>
<tr>
<td>Genitourinary</td>
<td>Mentioned in HPI</td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td>Arthritis</td>
</tr>
<tr>
<td>Skin</td>
<td>Negative</td>
</tr>
<tr>
<td>Neurological</td>
<td>Negative</td>
</tr>
<tr>
<td>Psychological</td>
<td>Negative</td>
</tr>
<tr>
<td>Endocrine</td>
<td>Diabetes Mellitus</td>
</tr>
<tr>
<td>Hematology</td>
<td>Negative</td>
</tr>
</tbody>
</table>

### PHYSICAL EXAMINATION:

- Patient does not appear in any respiratory, cardiac, or neurological distress. No pallor, jaundice, or cyanosis.
- Temperature: 97.9º F, Respiration 28/min, Pulse 72/min and regular
- Height: Weight: 155 lbs.
- Blood Pressure: Left (sitting): 166/72 mmHg Left (standing): 162/73 mmHg
- Eyes: Pupils are equal and reactive to light and accommodation. No evidence of conjunctivitis.
- Fundoscopy: Not done
- ENT: No hearing loss. Normal oropharyngeal and nasal mucosa.
- Neck: Normal jugular venous pressure. No carotid bruits.
- Lungs: Good air entry bilaterally. No wheezes or crackles.
- Heart: Regular S1, S2.
- Abdomen: Not done.
- Extremities: No edema.
- Neurologic: Patient was alert and oriented x 3. Cranial nerves II through XII were intact. Motor power was 5/5 bilaterally. Normal gait.
- Skin: No lesions or rashes.
- Other: None

### Diagnosis:
Hypertensive kidney disease, Renal Artery Stenosis. Direct face-to-face time spent with patient was 80 minutes. Meds reviewed and discussion about treatment and prognosis.

### Plan:
1. Increase the Toprol XL to 100 mg PO QD. Script written.
2. She will continue to monitor her BP at home.
3. She knows to call with any questions or concerns.
4. Return to clinic in 3-4 week with a basic metabolic panel.
5. Continue other medications for now.

A. 99215; 99354, 403.90, 585.9, 250.40, 483.81, V45.89, V58.67  
B. 99214; 403.90, 250.00, V45.89  
C. 99214; 99358, 401.9, 585.9, 440.1  
D. 99215; 99354, 401.9, 585.9, V45.89
Practice 10A, Report B

HOSPITAL-PROGRESS NOTE

CC: Worsening Acute Renal Failure

The patient was seen and examined multiple times today. His BUN was down to 40, sodium 135. His hiccups are better. He is getting them intermittently. His potassium was 3.9. He had no shortness of breath, no chest pain. Ultrasound was done. I evaluated him later in the evening. The patient was found to have right-sided hydronephrosis and right-sided hydroureter. I had a long discussion with him and his family and I discussed the case with the consulting physicians. We proceeded with right-sided percutaneous nephrostomy tube placement. The patient had bloody urine. He tolerated that procedure well. He was evaluated afterwards again. The patient also had a PD catheter placed, without difficulty and uneventfully.

EXAMINATION: The patient had no edema and felt well. His LUNGS are clear. His VITALS remain stable, BP 138/82, Pulse 126. He is afebrile.

I spent quite a bit of time with this patient today and with his family at bedside. Had lots of discussions on the different procedures that were done. His family asked a lot of questions. They were all answered. We discussed hemodialysis and peritoneal dialysis. We discussed nephrostomy tube and distal ureteric obstruction could be related to his surgery. We have addressed all of the concerns and issues. We discussed the fact that we might end up placing a stent, either cystoscopically or antegrade. I discussed this with his surgeon and we decided to proceed again tomorrow with antegrade stent placement.

IMPRESSION:
1. Acute renal failure.
2. Obstructive uropathy.
3. Right-sided hydronephrosis.
4. Chronic renal failure.
5. Hyponatremia from fluid overload state.

PLAN:
1. Hold dialysis for now.
2. Repeat laboratories in the morning.
3. High protein boost t.i.d.
5. We will proceed with antegrade stent placement.
6. Consult urologist.
7. The patient is code level 1.

Total time spent on this patient today was 2 hours and 25 minutes.

Codes:
Standby Services (99360)

Used when a physician, at request of attending physician, is standing by in case his/her services are needed.

Standby physician cannot be rendering services to another patient during standby time.

Reported in increments of 30 minutes.

Only reported when no service is performed and there is no face-to-face contact with the patient.

- Not reported when a standby status ends, and the physician provides a service to the patient.
- The service the physician provides is reported as any other service would be, even though it began as a Physician standby service.

CMS does not pay for standby services.

PRACTICE 10B, STANDBY SERVICES

These are time-based codes; therefore, no audit form is required. Once you have coded the two cases, check your answers in the answer key at the end of this PDF, where you will locate the answers and rationales.

Practice 10B, Report A

LOCATION: Outpatient Hospital

Surgeon is called in to be on standby for a female patient with proteinuria undergoing a biopsy of her right kidney. Specimen was sent for frozen section. Patient remains in surgery suite prepped for a procedure if diagnosis comes back malignant. Surgeon had been on standby for approximately 15 minutes when he received a call regarding another patient. Surgeon spent 6 minutes on the phone. Within 10 minutes of ending his call he was notified that his services was not needed as the biopsy came back negative for malignancy.

A. Not reportable/billable service
B. 99360
C. 50205-80
D. 99360-52

Practice 10B, Report B

LOCATION: Inpatient, Hospital

OB/GYN physician on call has asked me (Pediatrician) to standby due to 19-year-old patient in labor with fetal monitoring showing increased fetal distress. Patient is at 32-weeks gestation. Possible neonatal resuscitation may be required. After 1 hour and 40 minutes of constant standby, patient delivered without my assistance to newborn.

Codes:
11. CASE MANAGEMENT SERVICES (99363-99368)

Anticoagulant Management (99363, 99364)

Codes used to report anticoagulant (warfarin) therapy management
- Require physician review and interpretation
- Reported based initial or subsequent services
- Outpatient management only
- Assessments taken based on International Normalized Ratio (INR)
  - A system developed to report blood coagulation (clotting)
- Reported for each 90 days
  - Initial service must include a minimum of 8 assessments
  - Subsequent service must include at least 3 assessments
- Any period less than 60 days is not reported

Medical Team Conferences (99366-99368)

Management of complex cases involving individuals, such as
- Hospice patient
- Patient who is homebound and receives majority of health care from visiting nurse

Reported when a team of at least 3 different specialists meet to discuss
- Revising care plan
- Coordinating treatment plan with other professionals
- Adjusting therapies

Medical Team Conferences codes

Face-to-face with patient and/or family—99366
- Participation by nonphysician qualified health care professional
  - 30 minutes or more
Without patient and/or family—99367
- Participation by physician
  - 30 minutes or more
Without patient and/or family—99368
- Participation by nonphysician qualified health professional
  - 30 minutes or more
PRACTICE 11A, CASE MANAGEMENT SERVICES (99363-99368)

These are time- and complexity-based codes, so no audit form is required. Once you have coded the two cases, check your answers in the answer key at the end of this PDF, where you will locate the answers and rationales.

Practice 11A, Report A

PHONE CALL
I spoke to the family today in conference. Present were 2 sons, 1 daughter and the patient's husband. The interdisciplinary team of 5 was present for the conference. We spoke in great detail the prognosis of the patient and that the ongoing chemotherapy is not working and that decisions had to be made on behalf of the patient as far a code status. Besides the patient's stomach cancer with mets to the lungs, she is also deteriorating in regards to chronic interstitial pneumonia along with CHF. We explained to the family that the patient should be put on comfort measures, maybe bringing in hospice.

We will meet in my office next week to discuss this further.

The patient's prognosis is very grim, but we have left the decision to family to decide the care of their mother/wife. The conference lasted 45 minutes.

A. 99366; V66.7, 151.9, 197.0, 428.0, 515
B. 99367; V65.49, 151.9, 197.0, 428.5, 515
C. 99368; V66.7, 151.9, 197.0, 428.0, 515
D. 99366; V65.49, 151.9, 197.0, 428.0, 515

Practice 11A, Report B

TEAM CONFERENCE
This is an 87-year-old female who was discharged from the Rehabilitation Center to the Lilly Basic Care Facility. She was admitted with the diagnosis of nephritis and previous right below-the-knee amputation acquired. An interdisciplinary team of 4 met to discuss the best plan for this patient. No family was in attendance during the conference.

The patient's goal was to improve with her strength and overall health status. The patient has shown improvement with both her health status cares and mobility. At this time, she is ambulatory with the wheeled walker and her prosthetic and moderately independent. She is managing well enough at this time with mobility, transfers, and toileting to be a candidate for transition to a basic care facility. The basic care facility will provide assistance with bathing, meals, housekeeping, and medication monitoring. A physical therapy exercise program is planned. The patient does receive renal dialysis 3 days a week for her ESRD and will continue dialysis on Tuesday, Thursday, and Saturdays. She will receive her IV antibiotic dosing during her dialysis treatments under the direction of pharmacy. Dial-A-Ride has been arranged for transport for her Tuesday and Thursday appointments at dialysis and family will assist with transport for Saturday dialysis appointments. A referral has been made through County Social Service to assess eligibility for vouchers for the Saturday Dial-A-Ride. Referral information was faxed to the basic care facility on the day of discharge as requested. Family did provide transport at discharge. Time spent on conference was approximately 60 minutes.

Codes:
Anticoagulant Management (99363, 99364)

Codes used to report anticoagulant (warfarin) therapy management

- Require physician review and interpretation
- Reported based initial or subsequent services
- Outpatient management only
- Assessments taken based on International Normalized Ratio (INR)
  - A system developed to report blood coagulation (clotting)
- Reported for each 90 days
  - Initial service must include a minimum of 8 assessments
  - Subsequent service must include at least 3 assessments
- Any period less than 60 days is not reported
PRACTICE 11B, ANTICOAGULANT MANAGEMENT

These are time- and complexity-based codes, so no audit form is required. Once you have coded the two cases, check your answers in the answer key at the end of this PDF.

Practice 11B, Report A

LOCATION: Outpatient

Patient was initially seen in the office to establish an anticoagulant regiment. The patient had some high risk of clot formation, so the initial INR needed to be higher and he was started at 3.3. The tests and instruction were discussed with the patient. He returned for INR measurements and adjustment of his medications 9 times during the initial 3 months of therapy.

A. 99363
B. 99363, 99364
C. 99364
D. 99364, 99363

Practice 11B, Report B

LOCATION: Outpatient

The patient has been responding well to the initial 3 months of therapy and his dosage of warfarin was reduced significantly to 2.5 at the end of the initial 3-month treatment period. He was then seen once a month for the next 3 months for INR measurements. He responded well to treatment and his coagulation rates were within normal limits.

Codes:

The patient presented for warfarin therapy due to acute deep vein thrombosis of the lower legs.
12. CARE PLAN OVERSIGHT SERVICES (99374-99380)

Codes are divided according to whether physician is supervising a patient being cared for by
- Home health agency
- Hospice
- Nursing facility

Time-based codes
- 15-29 minutes
- 30 minutes or more

Reporting is by time over a month
- One physician may report the code per month

Reports physician supervision of patient, when patient is not present over a 30-day period

Patient resides in
- Own home
- Rest home or domiciliary
  - Includes assisted living facility or hospice

For patients under
- Home health care (99374-99375)
- Hospice (99377-99378)
- Nursing facility services (99379-99380)

Physician provides the following types of services
- Reviews subsequent reports, laboratory studies, or other studies
- Integrates new data into patient’s care plan
- Adjusts medical therapy
- Develops or revises care plans
- Communicates with other health care professionals
PRACTICE 12, CARE PLAN OVERSIGHT SERVICES (99374-99380)

Once you have coded the two cases, check your answers in the answer key at the end of this PDF, where you will locate the answers and rationales.

Practice 12, Report A

Care plan review of 77-year-old female in the local nursing facility. Patient suffers from advanced ovarian cancer and is currently receiving chemotherapy. Spoke with gynecologist and patient seems to be doing well with current treatments, although has increased pain. Per nurse's remarks in chart, patient seems to have increased edema in the lower extremities. Plan includes continuing with current dose of chemotherapy per gynecologist, IV morphine infusion for pain, and IV diuretics for edema. After reviewing her labs, I have ordered Aranesp 100 mcg if her hemoglobin drops below 12, currently it is 12.4. Documentation includes review of chart, nurse's remarks noted and medication adjustments of patient's care plan. Total time spent this month formulating care plan was 40 minutes.

A. 99367, 99380; 183.0, 338.3, 782.3
B. 99380; 183.0, 338.3, 782.3
C. 99308; V58.11, 183.0, 338.3, 782.3
D. 99380; V58.11, 183.0

Practice 12, Report B

CARE PLAN OVERSIGHT

Care plan oversight for terminal care of a 78-year-old male hospice patient with advanced lower lobe lung cancer. Plan includes continuous oxygen and pain control management involving IV morphine infusion. Have had contact with nurses, family members, and patient's social worker. Phone conference with patient's family to discuss concerns of continuing supportive care that the patient wishes to discontinue. Documentation includes review and modification of patient's care plan and orders to pharmacy. Total time spent this month formulating care plan was 45 minutes.

Codes:
13. PREVENTIVE MEDICINE SERVICES (99381-99429)

There are two categories under Preventive Medicine Services:

Preventive Medicine Services (99381-99397)

Counseling and/or Risk Factor Reduction Intervention (99401-99429)

Preventive Medicine Services (99381-99397)

Reports routine E/M for patient who is healthy and has no complaints.

Used to identify comprehensive services, not a single-system examination.

Such as an annual gynecologic examination.

Codes based on age and if new or established patient.

If physician encounters a problem or abnormality that requires significant additional service during preventative service:

Report appropriate level office visit code with modifier -25.

Code descriptions indicate terms “comprehensive history” and “comprehensive examination” are used.

Not same definition as in 99201-99350.

Comprehensive means a complete history and a complete examination appropriate for age/gender.

Examination is a multisystem examination.

Extent of examination is determined by age of patient and risk factors for patient.

Counseling and/or Risk Factor Reduction and Behavior Change Intervention (99401-99429)

Both new and established healthy patients.

Based on whether individual or group counseling is provided and time spent in service.

Used to report a physician’s services to a patient for risk factor interventional counseling.

Codes used to report services focused on promoting health and preventing illness/injury.

Patient does NOT have symptoms or an established illness.

If patient does have symptoms or an established illness, report service with appropriate E/M code.

Examples:

Diet and exercise program
Smoking cessation
Contraceptive management.
PRACTICE 13, PREVENTIVE MEDICINE SERVICES

These are age-based codes, so no audit form is required. Once you have coded the two cases, check your answers in the answer key at the end of this PDF.

Practice 13, Report A

SUBJECTIVE: This is an established 43-year-old white female, four previous pregnancies, two children, in today for a GYN exam and Pap smear with her annual physical exam. Her only concern is weight gain over the last couple of years. She had tried switching her antidepressant medicine from Zoloft to Wellbutrin and reacted very severely to the Wellbutrin. She is now back on Zoloft which she is aware can increase appetite. She has never tried portion control and increased exercise. She has generalized body aches.

CURRENT BIRTH CONTROL METHOD: She had a hysterectomy.

OTHER MEDICATIONS: 1. Protonix. 2. Lipitor. 3. Zoloft

ALLERGIES: Poppy seeds.

IMMUNIZATIONS: Tetanus and flu shot are up to date.

MENSTRUAL HISTORY: Hysterectomy for a bicornuate uterus. The cervix was adhesed on to the bladder so the cervical stub was left. Last Pap smear was August 2 years ago. Pap smears are being done every 2 to 4 years.

MEDICAL HISTORY, SOCIAL HISTORY, AND FAMILY HISTORY are unchanged since her last appointment. Please refer to consultation.

REVIEW OF SYSTEMS: No current HEENT, respiratory, cardiovascular, or breast problems. Irritable bowel symptoms are relieved by diet and Protonix. Multiple musculoskeletal problems related to bursitis and hip and back pain. No neurological, endocrine, or integumentary problems. Depression symptoms are well controlled by Zoloft.

PHYSICAL EXAMINATION: Declines the presence of a chaperone in the room today. Blood pressure: 106/66. Weight: 189. Height: 5 feet 5 inches. Thyroid is normal to palpation without enlargement. Cervical nodes are negative. Lungs are clear to auscultation without rates or wheezes. Heart: Regular rate and rhythm without murmurs. Breasts are normal to inspection and bilaterally symmetrical. Normal to palpation. No nipple discharge. Negative axillary nodes. Negative CVAT. Abdomen is soft without organomegaly or hernia. Vulva is normal to inspection. Normal hair distribution. Negative BUS. Negative inguinal nodes. Vagina has a scant amount of creamy discharge. Cervix is normal. A Pap smear was obtained. Bimanual exam shows no masses. Skin is warm and dry. Distal pulses are equal. No edema of the extremities.

ASSESSMENT:
2. Health maintenance issues.
PLAN:
1. We will notify her of her Pap within 2 weeks.
2. She will schedule a mammogram in the near future. Fasting lab work has all been done within the last 2 years.
3. Return to the clinic p.r.n. and for GYN care.

A. 99396; V70.0, V72.31
B. 99213; V70.0, 783.1
C. 99386; 783.1, 311
D. 99395; V70.0

Practice 13, Report B

Patient is a 44-year-old white female who comes to our office this afternoon for a yearly physical. She denies any active complaints. She is established with our clinic.

PMH: None.


MEDICATIONS: None.

ALLERGIES: NKA.

SOCIAL HISTORY: She smokes one pack of cigarettes per day for the last 20 years. She denies any history of alcohol or drug abuse. She is married and has three adult children. Her husband is currently in the service. She lives alone at home.

FAMILY HISTORY: Her father died at age 62 from unknown reasons. Her mother died at age 35 from unknown reasons. She has three brothers and one sister who are in good health.

PE: Declines the presence of a chaperone in the room today. Blood pressure: 108/78. Weight: 228 pounds. Height: 5 feet 5 inches. Thyroid is normal to palpation without enlargement. Cervical nodes are negative. Lungs are clear to auscultation without rates or wheezes. Heart: Regular rate and rhythm without murmurs. Breasts are normal to inspection and bilaterally symmetrical. Normal to palpation.

No nipple discharge. Negative axillary nodes. Abdomen is soft without organomegaly or hernia. Vulva is normal to inspection. Normal hair distribution. Negative BUS. Negative inguinal nodes. Vagina is clean with a scant amount of creamy discharge. On opening of the speculum to visualize the cervix, the patient complains of some discomfort and there is a slight amount of oozing at the posterior aspect of the cervical apex under the cervical stump. A Pap smear was obtained. Bimanual exam shows tenderness with deep penetration into the vagina and tenderness with cervical stump movement anteriorly. No masses palpated in the cut-de-sac or with bimanual exam. Skin is warm and dry. Distal pulses are equal. No edema of the extremities.

ASSESSMENT/PLAN:
1. Yearly physical done today with GYN examination.
2. Smoking cessation, tobacco dependence.

I talked to the patient about quitting smoking and she told me she has been thinking about it and will try. We will get a CBC, fasting CMP, fasting lipid panel, TSH, UA, EKG, chest x-ray, mammogram and stool occult cards x 3. The patient is scheduled for a follow-up visit in 1 month.

Codes:
14. NON-FACE-TO-FACE PHYSICIAN SERVICES (99441-99444); SPECIAL E/M SERVICES (99450-99456); AND OTHER E/M SERVICES (99499)

Non-Face-to-Face Physician Services (99441–99444)

Report physician E/M services using the telephone or internet

99441-99443 used to report telephone E/M services

Provided to an established patient, family member of the patient, or a guardian

Cannot originate from an E/M service within the previous 7 days

Cannot lead to an E/M service within the next 24 hours or the next available appointment

Reported based on the time documented in the medical record

99444 used to report online E/M services

Provided to an established patient, family member of the patient, or a guardian

Cannot originate from an E/M service within the previous 7 days

Cannot lead to an E/M service within the next 24 hours or the next available appointment

Special E/M Services (99450-99456)

Reports examination for life, work, or disability insurance

Establishes patient health baseline information

Provided in office or other setting

Reported for both new and established patients

If other E/M services provided the same day

Report additional service with appropriate E/M code(s)

99455 reports examination by treating physician

99456 reports examination by other than treating physician

Other E/M Services (99499)

99499 reports unlisted E/M services

Accompanied by a special report
PRACTICE 14, NON-FACE-TO-FACE PHYSICIAN SERVICES; SPECIAL E/M SERVICES; AND OTHER E/M SERVICES

No audit form is required for these codes. Once you have coded the two cases, check your answers in the answer key at the end of this PDF.

Practice 14, Report A

DISABILITY ASSESSMENT
This patient has suffered neck and low back injuries from an automobile accident. We determined from her Spinal Disability Evaluation that she has a Spinal Disability Rating of 50%.

Lost Pre-Injury Capacity: Disability precluding heavy lifting, repeated bending, stooping, and crawling. This individual has also lost approximately HALF of her pre-injury capacity of lifting, bending, stooping, and crawling.

Patient will continue with the prescribed chronic pain management regimen and ongoing physical therapy 3 times a week.

A. 99455; 723.1, 724.2, 846.8, E819.9
B. 99456; 723.1, 724.2, 905.7, E920.0
C. 99456; 723.1, 724.2, 846.8, E819.9
D. 99455; 723.1, 724.2, 338.21, 905.7, E929.0

Practice 14, Report B

DISABILITY ASSESSMENT
This is a 42-year-old man who has been disabled due to work-related trauma injury for about 6 months now. He is unable to use his hands or arms in any type of lifting due to carpal tunnel syndrome. Patient still has pain status post surgery.

The patient’s pain level today is 7 out of 10. He will continue with his prescribed medication at the current dosage. I will also consult physical therapy to strengthen his arms. I will see this patient back after his first treatment in therapy.

Completion of performance examination has been completed.

Codes:
15. NEWBORN CARE SERVICES (99460-99465)

99460-99463 reports initial and subsequent care in or in other than hospital/birthing center

For normal newborn infant, birth through 28 days

Reported per day

99463 reports initial hospital/birthing center when admission and discharge is same day

Newborn assessment includes Apgar assessment at 1 minute and 5 minutes after delivery

Physician assesses

Muscle tone (activity)

Heart rate (pulse)

Reflex response (grimace)

Color (appearance)

Breathing (respiration)

Each assessment area is assigned a rating of 0 to 2

Recorded on the newborn’s medical record

Delivery/Birthing Room Attendance and Resuscitation Services (99464-99465)

99464 reports attendance at delivery

Requested by delivering physician

Request for attendance must be documented in medical record

Provides initial stabilization

99465, resuscitation and ventilation

Attendance and resuscitation codes are not reported together
PRACTICE 15, NEWBORN CARE SERVICES

Once you have coded the two cases, check your answers in the answer key at the end of this PDF, where you will locate the answers and rationales.

Practice 15, Report A

36-week male born at 1:27 AM by vaginal delivery. APGAR 8/9. Disorganized suck, but once eating, takes 10-20 cc per feeding. Patient has (+) urine and stool output. Patient is discharged from the hospital the same day at 7:30 PM.

A. 99463; V30.1, 779.31
B. 99234; V30.1
C. 99234; V30.00, 779.31
D. 99463; V30.00

Practice 15, Report B

<table>
<thead>
<tr>
<th>Normal</th>
<th>Abnormal</th>
<th>ADMISSION EXAM</th>
<th>Date: 07/28/XX</th>
<th>DISCHARGE EXAM</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head/Fontanels</td>
<td>✓</td>
<td>Scalp bruised due to birth injury</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eyes</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ears/Nose/Throat</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lungs</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abdomen</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trunk/Spine</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anus</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genitalia</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Negative Barlow Test</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Negative Ortolani Test</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extremities/Clavicles</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neurological/Tone</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

PROGRESS NOTES: 07/29/XX

Day two: Vitals stable, afebrile. Exam is unchanged.

(+T) urine and stool. Weight is up 2.3%.

Continue normal newborn care.

Codes:
16. INPATIENT NEONATAL INTENSIVE CARE SERVICES AND PEDIATRIC AND NEONATAL CRITICAL CARE SERVICES
(99466-99480)

Neonatal and Pediatric Critical Care Services (99466-99480)
Pediatric Patient Transport (99466, 99467)
  First 30-74 minutes
  Each additional 30 minutes
Reports interfacility transport (this is transport from one facility to another and not a step down unit)
  Critically ill or injured patient
Patients that are 24 months or less
Physician must be face-to-face with the patient

Inpatient Neonatal Critical Care Services (99468, 99469)
Divided by
  Initial day
  Subsequent day
Critically ill neonate
Age 28 days or younger

Inpatient Pediatric Critical Care Services (99471-99476)
Inpatient services
Divided by age
  29 days-24 months
  2-5 years
Subdivided on day
  Initial
  Subsequent

Initial and Continuing Intensive Care Services (99477-99480)
Hospital Care
Divided on
  Age
    28 days or younger
  Birth weight
    Very low birth weight (VLBW) ≤1500 grams (≤3.3 pounds)
    Low birth weight (LBW) 1500-2500 grams (3.31-5.5 pounds)
    Normal birth weight 2501-5000 grams (5.51-11.01 pounds)
Subdivided on day
  Initial
  Subsequent
PRACTICE 16, INPATIENT NEONATAL INTENSIVE CARE SERVICES
AND PEDIATRIC AND NEONATAL CRITICAL CARE SERVICES

These are time-based codes, so no audit form is required. Once you have coded the two cases, check your answers in the answer key at the end of this PDF, where you will locate the answers and written rationales.

Practice 16A, Report A

The physician accompanies a 13-month-old critical-care patient during transport from one hospital to another. The documented time spent was 1 ½ hours with the patient in the first hospital, 2 hours transporting the patient to the second hospital.

A. 99479, 99467 ×2
B. 99466, 99467 ×5
C. 99466, 99467 ×2
D. 99291, 99292, 99466, 99467

Practice 16A, Report B

Total of 2 hours, 40 minutes spent with 18-month-old burn patient that went into shock. Patient was be transported to The Children’s Burn Center by air flight.

Codes:
**Practice 16B, Report A**

**NICU INPATIENT PROGRESS NOTE**

**S:** No acute events overnight, brief cardiac bradycardia arrhythmia, sleep study overnight

**O:**
- Resp: Rate: 32-76, Exam: Upper airway congestion
- CV: Rate: 94-154, Map: 50-69
  - Exam: RRR, good perfusion
- FEN/GI: I: 630, TF: 134, Wt: 4696 grams
- O: 345
  - Exam: Soft NT ND with +BS
- HEME: none
- GU: Within normal limits.
- ID: Temp Max: 36.7
- Cultures: none
- NEURO:
  - Exam: warm, no edema. Alert and appropriate, good tone

**A/P:** 2 month 1 wk old male was admitted for a unilateral, incarcerated inguinal hernia and subsequently developed acute pneumonia. Sleep study done yesterday. Continue to monitor perfusion. Continue with 22 kcal feedings.

A. No code; post-operative global period
B. 99231; 764.09, V45.89, 550.10
C. 99480; 550.10, 486, 427.89
D. 99480; 550.10, 486, V45.89

---

**Practice 16B, Report B**

**NICU INPATIENT**

**S:** Quiet night

**O:**
- Resp: Rate: 26-73, Exam: Lungs clear
- CV: Rate: 131-174, Map: 44-51
  - Exam:
- FEN/GI: I: 250, TF: 133, Wt: 2100 grams
- O: 138
  - Exam: Abd soft with +BS
- HEME:
- ID: Temp Max: 37
- Cultures: 0
- NEURO:
  - Exam: AF soft, ext: good tone

**A/P:** 55 day old, 27 week premature, resp stable, PE benign. Occ desats monitor. Follow up echo this week to look at coronary arteries. Monitor weight.

**Codes:**
**Answers**

### EVALUATION AND MANAGEMENT (E/M) LECTURE ANSWERS

**PRACTICE 1, OFFICE OR OTHER OUTPATIENT SERVICES**

#### Practice 1, Report A

**Rationale:**

A. Incorrect because the key components of this evaluation consist of an expanded problem focused (EPF) history, detailed expanded problem focused examination and low medical decision making (MDM). **99212** would be undercoding.

B. Incorrect because even though **99213** is the correct service code, the diagnosis of cough (786.2) would not be coded because it is a symptom of the acute bronchitis.

C. **Correct because the service code is for an established office service, which consists of an expanded problem focused history, expanded problem focused examination, and moderate MDM. Office and Other Outpatient Services codes require 2 of the 3 key components to qualify for assignment and the documentation supports assignment of this code. The diagnosis is correct with 466.0 (Bronchitis, acute) reported for the bronchitis since the documentation does specify the type (acute).**

D. Incorrect because **99202** is for a new patient, and this note states that the patient is established.

#### Practice 1, Report B

**Professional Services:** **99213** (Evaluation and Management, Office and Other Outpatient); **577.0** (Pancreatitis, acute), **577.2** (Pseudocyst, pancreas)

**Rationale:** The patient is an established patient. The history of present illness (HPI) includes the location (abdomen), duration (4 months), and associated signs and symptoms (fever) for a total of 3, which is a level 2 or expanded problem focused HPI. One review of systems (ROS) (gastrointestinal) was performed for a level 2 or expanded problem focused ROS. Only the patient’s past medical history (cholecystectomy) was discussed for a level 3 or detailed
past, family, and social history (PFSH). All 3 elements of a patient’s history have to be at the same level or higher when choosing the level of history. This documentation contained a level 2 or problem focused HPI, a level 2 or problem focused ROS and a level 3 or problem focused PFSH. The history level would therefore be a level 2 or expanded problem focused history because the lowest level is 2.

The examination included only 1 element of constitutional (general appearance) for 1 OS. The abdomen was soft for 1 BA. No organ systems were examined. There is a total of 2 BA/OS examined for an expanded problem focused or level 2 examination.

The MDM consisted of multiple diagnoses (acute pancreatitis, pseudocyst, past surgery to consider), limited data was reviewed, and the patient has a moderate risk of complication (established problem, not improving). To qualify for a given level of MDM complexity, 2 of 3 elements must be met or exceeded and this MDM is a level 3 or moderate.

The levels included level 2 or expanded problem focused HPI; level 2 or expanded problem focused examination, and a level 3 or moderate MDM. Because this is an established patient, only 2 of the 3 key components need to be met or exceeded to assign the code. The documentation qualifies for assignment of 99213.

The primary reason for the office service is the persisting generalized abdominal pain (789.07); the report states she has acute pancreatitis (577.0) and since abdominal pain is a symptom of pancreatitis, it is not reported. A pseudocyst of the pancreas (577.2) was found on CT scan. The correct diagnoses are acute pancreatitis (577.0) and pseudocyst of the pancreas (577.2).
### Practice 1, Report B

<table>
<thead>
<tr>
<th>HISTORY ELEMENTS</th>
<th>Documented</th>
</tr>
</thead>
<tbody>
<tr>
<td>HISTORY OF PRESENT ILLNESS (HP)</td>
<td></td>
</tr>
<tr>
<td>1. Location (site on body)</td>
<td>✓</td>
</tr>
<tr>
<td>2. Quality (characteristic: throbbing, sharp)</td>
<td></td>
</tr>
<tr>
<td>3. Severity (1-10 or how intense)</td>
<td></td>
</tr>
<tr>
<td>4. Duration* (how long for problem or episode)</td>
<td>✓</td>
</tr>
<tr>
<td>5. Timing (when it occurs)</td>
<td></td>
</tr>
<tr>
<td>6. Context (under what circumstances does it occur)</td>
<td></td>
</tr>
<tr>
<td>7. Modifying factors (what makes it better or worse)</td>
<td></td>
</tr>
<tr>
<td>8. Associated signs and symptoms (what else is happening when it occurs)</td>
<td>✓</td>
</tr>
<tr>
<td>*Duration not in CPT as HP Element</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>3</td>
</tr>
<tr>
<td>LEVEL</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>REVIEW OF SYSTEMS (ROS)</th>
<th>Documented</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Constitutional (e.g., weight loss, fever)</td>
<td></td>
</tr>
<tr>
<td>2. Ophthalmologic (eyes)</td>
<td></td>
</tr>
<tr>
<td>3. Otolaryngologic (ears, nose, mouth, throat)</td>
<td></td>
</tr>
<tr>
<td>4. Cardiovascular</td>
<td></td>
</tr>
<tr>
<td>5. Respiratory</td>
<td></td>
</tr>
<tr>
<td>6. Gastrointestinal</td>
<td></td>
</tr>
<tr>
<td>7. Genitourinary</td>
<td></td>
</tr>
<tr>
<td>8. Musculoskeletal</td>
<td></td>
</tr>
<tr>
<td>9. Integumentary (skin and/or breasts)</td>
<td></td>
</tr>
<tr>
<td>10. Neurological</td>
<td></td>
</tr>
<tr>
<td>11. Psychiatric</td>
<td></td>
</tr>
<tr>
<td>12. Endocrine</td>
<td></td>
</tr>
<tr>
<td>13. Hematologic/Lymphatic</td>
<td></td>
</tr>
<tr>
<td>14. Allergic/Immunologic</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>1</td>
</tr>
<tr>
<td>LEVEL</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PAST, FAMILY, AND/OR SOCIAL HISTORY (PFSH)</th>
<th>Documented</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Past illness, operations, injuries, treatments, and current medications</td>
<td>✓</td>
</tr>
<tr>
<td>2. Family medical history for heredity and risk</td>
<td></td>
</tr>
<tr>
<td>3. Social activities, both past and present</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>1</td>
</tr>
<tr>
<td>LEVEL</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>History Level</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>HPF</td>
<td>Problem Focused</td>
<td>Expanded Problem Focused</td>
<td>Detailed</td>
<td>Comprehensive</td>
</tr>
<tr>
<td>ROS</td>
<td>None</td>
<td>Problem Pertinent 1</td>
<td>Extended 2-9</td>
<td>Complete 10+</td>
</tr>
<tr>
<td>PFSH</td>
<td>None</td>
<td>None</td>
<td>Pertinent 1</td>
<td>Complete 2-3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MDM ELEMENTS</th>
<th>Documented</th>
</tr>
</thead>
<tbody>
<tr>
<td># OF DIAGNOSIS/MANAGEMENT OPTIONS</td>
<td></td>
</tr>
<tr>
<td>1. Minimal</td>
<td>✓</td>
</tr>
<tr>
<td>2. Limited</td>
<td></td>
</tr>
<tr>
<td>3. Multiple</td>
<td></td>
</tr>
<tr>
<td>4. Extensive</td>
<td></td>
</tr>
<tr>
<td>LEVEL</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>AMOUNT AND/OR COMPLEXITY OF DATA TO REVIEW</th>
<th>Documented</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Minimal/None</td>
<td></td>
</tr>
<tr>
<td>2. Limited</td>
<td>✓</td>
</tr>
<tr>
<td>3. Moderate</td>
<td></td>
</tr>
<tr>
<td>4. Extensive</td>
<td></td>
</tr>
<tr>
<td>LEVEL</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>RISK OF COMPLICATION OR DEATH IF NOT TREATED</th>
<th>Documented</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Minimal</td>
<td></td>
</tr>
<tr>
<td>2. Low</td>
<td>✓</td>
</tr>
<tr>
<td>3. Moderate</td>
<td></td>
</tr>
<tr>
<td>4. High</td>
<td></td>
</tr>
<tr>
<td>LEVEL</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MDM</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of DX or management options</td>
<td>Minimal</td>
<td>Limited</td>
<td>Multiple</td>
<td>Extensive</td>
</tr>
<tr>
<td>Amount and/or complexity of data</td>
<td>Minimal/None</td>
<td>Limited</td>
<td>Moderate</td>
<td>Extensive</td>
</tr>
<tr>
<td>Risks</td>
<td>Minimal</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
</tr>
</tbody>
</table>

*To qualify for a given type of MDM complexity, 2 of 3 elements in the table must be met or exceeded.

### EXAMINATION ELEMENTS

<table>
<thead>
<tr>
<th>CONSTITUTIONAL (OS)</th>
<th>Documented</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Blood pressure, sitting</td>
<td></td>
</tr>
<tr>
<td>2. Blood pressure, lying</td>
<td></td>
</tr>
<tr>
<td>3. Pulse</td>
<td></td>
</tr>
<tr>
<td>4. Respirations</td>
<td></td>
</tr>
<tr>
<td>5. Temperature</td>
<td></td>
</tr>
<tr>
<td>6. Weight</td>
<td></td>
</tr>
<tr>
<td>7. General appearance</td>
<td>✓</td>
</tr>
<tr>
<td><em>Counts only as 1</em></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BODY AREAS (BA)</th>
<th>Documented</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Head (including face)</td>
<td></td>
</tr>
<tr>
<td>2. Neck</td>
<td>✓</td>
</tr>
<tr>
<td>3. Chest (including breasts and axillae)</td>
<td></td>
</tr>
<tr>
<td>4. Abdomen</td>
<td></td>
</tr>
<tr>
<td>5. Genitalia, groin, buttocks</td>
<td></td>
</tr>
<tr>
<td>6. Back (including spine)</td>
<td></td>
</tr>
<tr>
<td>7. Each extremity</td>
<td></td>
</tr>
<tr>
<td><em>Counts only as 1</em></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ORGAN SYSTEMS (OS)</th>
<th>Documented</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Ophthalmologic (eyes)</td>
<td></td>
</tr>
<tr>
<td>2. Otolaryngologic (ears, nose, mouth, throat)</td>
<td></td>
</tr>
<tr>
<td>3. Cardiovascular</td>
<td></td>
</tr>
<tr>
<td>4. Respiratory</td>
<td></td>
</tr>
<tr>
<td>5. Gastrointestinal</td>
<td></td>
</tr>
<tr>
<td>6. Genitourinary</td>
<td></td>
</tr>
<tr>
<td>7. Musculoskeletal</td>
<td></td>
</tr>
<tr>
<td>8. Integumentary (skin)</td>
<td></td>
</tr>
<tr>
<td>9. Neurologic</td>
<td></td>
</tr>
<tr>
<td>10. Psychiatric</td>
<td></td>
</tr>
<tr>
<td>11. Hematologic/Lymphatic/Immunologic</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EXAMINATION LEVEL</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Key Components: 2 of 3</td>
<td>99213</td>
</tr>
</tbody>
</table>

Copyright © 2010, 2009, 2008, Elsevier Inc. All rights reserved.
PRACTICE 2, HOSPITAL OBSERVATION SERVICES

Practice 2, Report A

Rationale:
A. Incorrect because the elements documented do not support a 99220 level of service. Diagnosis coding is incorrect.
B. Incorrect because prolonged service exclusions do not permit assignment of 99354 and 99355 with 99218. Diagnosis coding is also incorrect.
C. Incorrect because the cough 786.2 and abnormal findings on radiological examination (793.1) are missing and a CT scan was ordered for next week to assess these two conditions. The Index indicates that 583.81, which is missing, should be coded with 250.42. CPT coding is correct.
D. Correct answer because the elements documents, detailed history, detailed exam and high MDM make the Observation level 99218. The patient presents with uncontrolled type 2 diabetes (250.42) and end stage renal disease (585.6) treated with peritoneal dialysis (V45.11). The Index shows 250.4 [583.81] indicating that diabetes with nephropathy, 250.42, must be followed by 583.81 to indicate nephrosis/nephritis in diseases classified elsewhere. End-stage renal disease 585.6 follows to indicate the severity of the diabetic nephropathy. The report states that the patient is going to be admitted for observation primarily to control his blood sugar levels, so the 5th digit 2 in 250.42 to indicate uncontrolled diabetes. The patient has a cough (786.2) and bilateral lung infiltrates on chest x-ray (793.1), and a CT is to be scheduled the following week to assess both of these conditions. Also noted in the report is the elevated protein (790.99) and low albumin (790.99). The code is only reported once, 790.99. The leg edema (782.3) and depression (311) may be considered; however, these conditions were not addressed so are not reported. Noncompliance with medical treatment (V15.81) and long-term (current) use of insulin (V48.67) could also be reported for this case.

Practice 2, Report B

Professional Services: 99217 (Evaluation and Management, Hospital Service, Observation Care); 440.1 (Stenosis, renal artery), 997.72 (Complications, surgical procedures, vascular, renal artery), 458.9 (Hypotension), 403.90 (Disease/diseased, renovascular), 585.9 (Disease/diseased, renal, chronic), 285.1 (Anemia, due to, blood loss, chronic)

Rationale: There is no audit form with this case because the hospital observation discharge service is not based on the key components of history, exam, and MDM. There is only one CPT code for a hospital observation discharge—99217.

This patient was admitted to Observation after an outpatient angioplasty for renal stenosis. The Guidelines, Section IV.A.2. Observation stay state that when a patient presents for outpatient surgery and develops complications requiring admission to observation, code the reason for the surgery as the first-reported diagnosis (reason for the encounter), followed by codes for the complications as secondary diagnoses. The first-listed diagnosis then is renal stenosis (440.1) followed by the complications of peri-procedural bleeding (997.72) which caused hypotension (458.9). This patient has chronic renal failure secondary to hypertensive renovascular disease. According to the Official Guidelines for
Coding and Reporting, Section I.C.7.a.3: “Assign codes from category 403, Hypertensive chronic kidney disease, when conditions classified to categories 585 are present. Unlike hypertension with heart disease, ICD-9-CM presumes a cause-and-effect relationship and classifies chronic kidney disease (CKD) with hypertension as hypertensive chronic kidney disease. Fifth digits for category 403 should be assigned as follows: 0 with CKD stage I through stage IV, or unspecified. 1 with CKD stage V or end stage renal disease. The appropriate code from category 585, Chronic kidney disease, should be used as a secondary code with a code from category 403 to identify the stage of chronic kidney disease.” Therefore, the renovascular disease is reported with 403.90, with fifth digit 0 to indicate unspecified or chronic kidney disease stages I through IV. 585.9 is reported for the CRF (chronic renal failure). Code 285.1 (Anemia secondary to blood loss, acute) is also reported as it has been addressed.
PRACTICE 3, HOSPITAL INPATIENT SERVICES

Practice 3, Report A

Answer/Rationale:
A. This choice is incorrect because **99205**, initial office service, would not be reported, because only one E/M service is billable per provider per day, and the service provided by the physician in the office would be “bundled” into the documentation for the initial hospital service.

B. Is correct. **99223** is reported because the office visit and all services provided in that setting are considered when choosing the hospital admission code. To assign a code from this subcategory all three key components must meet or exceed the level in the code. The history and examination were comprehensive and the MDM was high.

C. This choice is incorrect. CPT **99215** is for an established patient office service and would not be reported because only one E/M service is billable per provider per day and the work done by the physician in the office would be “bundled” into the documentation for the initial hospital service.

D. This choice is incorrect. **99221** is for a level 1 initial hospital service. The history and exam are comprehensive, but the MDM documented is high, rather than straightforward or low, making this incorrect.

Practice 3, Report B

Professional Services: **99238** (Evaluation and Management, Hospital, Discharge); **578.9** (GI Bleed), **285.1** (Anemia, due to blood loss, acute). **414.01** (Arteriosclerosis/arteriosclerotic, coronary, artery), **443.9** (Disease/diseased, peripheral vascular); **496** (Disease/diseased, lung, obstructive [chronic], COPD); **V45.82** (Status [post], angioplasty, percutaneous transluminal, coronary)

Rationale: Hospital discharges are based on time. If the documentation does not specify time spent discharging the patient, then the lowest level code must be assigned (**99238**). No audit form is needed with time based codes. The service may or may not include an examination of the patient.

The diagnoses are stated in the final diagnosis area of the discharge summary. The acute GI bleed (**458.9**) and anemia due to blood loss (**285.1**) are reported even though they are listed as stable, which means that the condition is under control. When referencing the Index under “Disease, artery, coronary,” you are directed to “see Arteriosclerosis, coronary” (**414.00**). The fifth digit of “0” is assigned because the documentation does not state if this disease is in the patient’s native vessel or in a previously grafted vessel; however, Coding Clinic states to report “1” is unknown (**414.01**). The PVD (peripheral vascular disease) (**443.9**), COPD (**496**) and the post-procedural status of stent placement (**V45.82**) are also reported.
PRACTICE 4. CONSULTATIONS

Practice 4, Report A

Rationale:
A. Is the correct answer. The service is a consultation, based on the opening statement thanking for the referral and the reason for it. The consultation codes require 3 of 3 elements. This case had a detailed history and physical exam and moderate MDM, a level 3 consultation. To assign the level 4 requires a comprehensive history and physical exam components.

B. This choice is incorrect. CPT 99244 requires a comprehensive history and physical exam and the documentation in this scenario did not meet those criteria. The decision making is moderate and meets this level, but 3 of 3 key components must be met or exceeded to select a level and only MDM meets this level.

C. This choice is incorrect. CPT 99203 is for a new patient office service, and this scenario is for a consultation.

D. This choice is incorrect. CPT 99215 is for an established patient office service, and this scenario is for a consultation.

Practice 4, Report B

Professional Services: 99253 (Evaluation and Management, Consultation); 787.01 (Nausea, with vomiting). 789.00 (Pain(s), abdominal, unspecified site). 790.4 (Elevation, transaminase). 250.60 (Diabetes with gastroparesis). 536.3 (Diabetic gastroparalysis). V58.69 (Long-term [current] drug use, methadone/opioids). V58.67 (Long-term [current] drug use, insulin). V44.2 (Status, gastrostomy)

Rationale: The physician has been asked to evaluate the patient for possible cause of her nausea, vomiting, and abdominal pain. There are 4 elements of HPI: location (abdomen), duration (2 days), context (intake-tube placement 2004), and associated signs and symptoms (constipation) for a level 4 or comprehensive HPI. Six systems were reviewed: constitutional (denies fever or chills), cardiovascular (denies chest pain), respiratory (denies shortness of breath), gastrointestinal (on tube feedings, denies change in bowel movements, denies melena, GERD), and genitourinary (denies dysuria), and endocrine (diabetic) for a level 3, detailed ROS. The PFSH includes: past (hypertension, diabetic gastroparesis), family (no GI problems) and social (does not smoke or drink) for a level 4 or complete PFSH. A comprehensive HPI, detailed ROS and comprehensive PFSH make this a detailed history.

The examination consists of 4 constitutional elements (temperature, pulse, blood pressure, general appearance) that count as 1 OS. The BAs that were examined include neck, abdomen, and all 4 extremities for a total of 6 BAs. A total of 6 additional OSs, ophthalmologic (PERRL, extraocular motion intact), otolaryngologic (oropharynx benign, mucous membranes moist), cardiovascular (regular rate and rhythm, S1, S2 normal), respiratory (clear to auscultation bilaterally), gastrointestinal (no hepatosplenomegaly or mass), and neurologic (intact) were examined. This is a total of 6 BAs and 7 OSs for a level 3, or detailed examination. At least 8 OSs are required for a comprehensive level examination.

Level 4 or Extensive diagnosis/management options (surgical consult called for surgery), level 3 or moderate data were reviewed (labs, x-ray, reviewed x-rays), and the patient has level 4 or high risk (make have biliary obstruction, evaluation for small bowel obstruction/possible surgery) that makes this a level 4 or high MDM.
The detailed history, detailed level examination and high medical decision making make this consult 99253.

ICD-9-CM—The first diagnosis under the physician's impression states that these symptoms could represent diabetic gastroparesis, which is also known as delayed gastric emptying due to paralysis of the stomach muscles. This patient already has a gastrostomy for feedings for diabetic gastroparesis which may be causing the problems 250.60, [536.3]. The Index indicates that 250.60 is listed before the gastroparesis, 536.3. A definitive diagnosis has not been made; therefore, report the symptoms nausea, with vomiting (787.01) and abdominal pain (789.00). The fifth digit on abdominal pain (789.00) is “0” for unspecified abdominal pain because no further indication of location was documented. Also reported is the elevated transaminase (790.4). The diabetes is reported with as indicated above 250.60, 536.3. She is also on long-term methadone as well as Duragesic which could be causing the ileus (V58.69). The patient is also status gastrostomy (V44.2) and status long-term insulin use (V58.67).
## Practice 4, Report B

### History Elements

<table>
<thead>
<tr>
<th>History of Present Illness (HPI)</th>
<th>Documented</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Location (site on body)</td>
<td>√</td>
</tr>
<tr>
<td>2. Quality (characteristic; throbbing, sharp)</td>
<td></td>
</tr>
<tr>
<td>3. Severity (I/IU or how intense)</td>
<td></td>
</tr>
<tr>
<td>4. Duration* (how long for problem or episode)</td>
<td>√</td>
</tr>
<tr>
<td>5. Timing (when it occurs)</td>
<td></td>
</tr>
<tr>
<td>6. Context (under what circumstances does it occur)</td>
<td></td>
</tr>
<tr>
<td>7. Modifying factors (what makes it better or worse)</td>
<td>√</td>
</tr>
<tr>
<td>8. Associated signs and symptoms (what else is happening when it occurs)</td>
<td>√</td>
</tr>
<tr>
<td>*Duration not in CPT as HPI Element</td>
<td>TOTAL: 4</td>
</tr>
<tr>
<td></td>
<td>LEVEL: 4</td>
</tr>
</tbody>
</table>

### Review of Systems (ROS)

<table>
<thead>
<tr>
<th>Documented</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Constitutional (e.g., weight, loss, fever)</td>
</tr>
<tr>
<td>2. Ophthalmologic (eyes)</td>
</tr>
<tr>
<td>3. Otolaryngologic (ears, nose, mouth, throat)</td>
</tr>
<tr>
<td>4. Cardiovascular</td>
</tr>
<tr>
<td>5. Respiratory</td>
</tr>
<tr>
<td>6. Gastrointestinal</td>
</tr>
<tr>
<td>7. Genitourinary</td>
</tr>
<tr>
<td>8. Musculoskeletal</td>
</tr>
<tr>
<td>9. Integumentary (skin and/or breasts)</td>
</tr>
<tr>
<td>10. Neurological</td>
</tr>
<tr>
<td>11. Psychiatric</td>
</tr>
<tr>
<td>12. Endocrine</td>
</tr>
<tr>
<td>13. Hematologic/Lymphatic</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

### Past, Family, and/or Social History (PFSH)

<table>
<thead>
<tr>
<th>Documented</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Past illness, operations, injuries, treatments, and current medications</td>
</tr>
<tr>
<td>2. Family medical history for heredi and risk</td>
</tr>
<tr>
<td>3. Social activities, both past and present</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

### History Level

<table>
<thead>
<tr>
<th>History Level</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem Focused</td>
<td>Expanded Problem Focused</td>
<td>Detailed</td>
<td>Comprehensive</td>
<td></td>
</tr>
<tr>
<td>HPI</td>
<td>Brief 1-3</td>
<td>Brief 1-3</td>
<td>Extended 4+</td>
<td>Extended 4+</td>
</tr>
<tr>
<td>ROS</td>
<td>None</td>
<td>Problem Pertinent 1</td>
<td>Extended 2-9</td>
<td>Complete 10+</td>
</tr>
<tr>
<td>PFSH</td>
<td>None</td>
<td>None</td>
<td>Pertinent 1</td>
<td>Complete 2-3</td>
</tr>
</tbody>
</table>

### Examination Elements

<table>
<thead>
<tr>
<th>Examine Level</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem Focused</td>
<td>Expanded Problem Focused</td>
<td>Detailed</td>
<td>Comprehensive</td>
<td></td>
</tr>
<tr>
<td>Limited to affected BA/OS</td>
<td>Limited to affected BA/OS &amp; other related OS(s)</td>
<td>Extended of affected BA(s) &amp; other related OS(s)</td>
<td>General multi-system</td>
<td></td>
</tr>
<tr>
<td># of OS or BA</td>
<td>1</td>
<td>2-7 limited</td>
<td>2-7 extended</td>
<td>B+</td>
</tr>
</tbody>
</table>

### Examination Level

<table>
<thead>
<tr>
<th>Examination Level</th>
<th>4</th>
</tr>
</thead>
</table>

### MDM Elements

<table>
<thead>
<tr>
<th># of Diagnosis/Management Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Minimal</td>
</tr>
<tr>
<td>2. Limited</td>
</tr>
<tr>
<td>3. Multiple</td>
</tr>
<tr>
<td>4. Extensive</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

### AMOUNT AND/OR COMPLEXITY OF DATA TO REVIEW

<table>
<thead>
<tr>
<th>Documented</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Minimal/None</td>
</tr>
<tr>
<td>2. Limited</td>
</tr>
<tr>
<td>3. Moderate</td>
</tr>
<tr>
<td>4. Extensive</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

### RISK OF COMPLICATION OR DEATH IF NOT TREATED

<table>
<thead>
<tr>
<th>Documented</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Minimal</td>
</tr>
<tr>
<td>2. Low</td>
</tr>
<tr>
<td>3. Moderate</td>
</tr>
<tr>
<td>4. High</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

### MDM

<table>
<thead>
<tr>
<th>Documented</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of DX or management options</td>
</tr>
<tr>
<td>Amount and/or complexity of data</td>
</tr>
<tr>
<td>Risks</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

*To qualify for a given type of MDM complexity, 2 of 3 elements in the table must be met or exceeded.

---

**Answers**

<table>
<thead>
<tr>
<th>CONSTITUTIONAL (OS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Blood pressure, sitting</td>
</tr>
<tr>
<td>• Blood pressure, lying</td>
</tr>
<tr>
<td>• Pulse</td>
</tr>
<tr>
<td>• Respirations</td>
</tr>
<tr>
<td>• Temperature</td>
</tr>
<tr>
<td>• Height</td>
</tr>
<tr>
<td>• Weight</td>
</tr>
<tr>
<td>• General appearance</td>
</tr>
</tbody>
</table>

**Body Areas (BA)**

<table>
<thead>
<tr>
<th>Documented</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Head (including face)</td>
</tr>
<tr>
<td>2. Neck</td>
</tr>
<tr>
<td>3. Chest (including breasts and axillary)</td>
</tr>
<tr>
<td>4. Abdomen</td>
</tr>
<tr>
<td>5. Genitalia, groin, buttocks</td>
</tr>
<tr>
<td>6. Back (including spine)</td>
</tr>
</tbody>
</table>

**Risks**

<table>
<thead>
<tr>
<th>Documented</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
</tr>
<tr>
<td>Moderate</td>
</tr>
<tr>
<td>Limited</td>
</tr>
<tr>
<td>None</td>
</tr>
</tbody>
</table>

**History:** Detailed

**Examination:** Comprehensive

**MDM:** Moderate

**Number of Key Components:** 3 of 3

99253

---

**Copyright © 2010, 2009, 2008, Elsevier Inc. All rights reserved.**
PRACTICE 5, EMERGENCY DEPARTMENT SERVICES

Practice 5, Report A

Rationale:
A. This is the correct answer. Using the acuity sheet, this is an ED encounter (99284) and the highest level of service was the administration of intravenous (IV) medications, level 4, point 10. 789.09 is assigned to report the abdominal pain with fifth digit 9 to indicate other specified site, because patient's complaint and examination indicate upper abdominal, diffuse and right upper quadrant. The nausea is reported with 787.02 and the diarrhea with 787.91. Note that the viral syndrome (079.99) is not reported because provider indicated this as “probable” diagnosis and probable diagnoses are not reported in the outpatient setting. Also not reported are asthma, hypertension, depression, migraines, esophageal reflux, or arthritis, because none of these conditions were treated or were documented to affect treatment.

B. This choice is incorrect. 99285 requires a level of service as indicated on the acuity sheet and the highest level of service in this case was level 4, point 10, administration of IV medication. The diagnosis is also incorrect as 789.00 reports abdominal pain of an unspecified site and the report indicated upper abdominal pain (fifth digit 9). 079.9, viral syndrome, is incorrect because the diagnostic statement indicated the viral syndrome was a probable diagnosis. Also missing from this selection is the nausea reported with 787.02 and the diarrhea reported with 787.91.

C. This choice is incorrect. 99283 is too low a level of service because level 4, point 10 specifies administration of an IV medication and the documentation in this case indicated that level of service. Also documented was the level 3, point 4 service of prescription medication administration, but code selection should always be the highest code available that is supported by the provider's documentation or the service is undercoded. Diagnosis of 789.00 (abdominal pain, unspecified site) is incorrect, because the documentation indicates specific points of pain, 789.09. Also missing from this selection is the nausea reported with 787.02 and the diarrhea reported with 787.91.

D. This choice is incorrect. Although 99284 is correct with 789.09 (abdominal pain, other specified site), 079.99 (unspecified viral infection) is not reported because it is documented as “probable,” and probable diagnoses are not reported in the outpatient setting. Also missing from this selection is the nausea reported with 787.02 and the diarrhea reported with 787.91.

Practice 5, Report B

Professional Services: 99283 (Evaluation and Management, Emergency Department); 845.00 (Sprain, strain, ankle), E885.2 (Fall/falling, from, off, skateboard)

Rationale: The patient presents to the emergency room complaining of ankle pain due to a fall. Using the ED acuity sheet, the highest level of service is level 3, point 3, x-ray of one area, reported with 99283. The ankle was not fractured, but sprained (845.00). The external cause of the injury was a fall from a skateboard (E885.2).
PRACTICE 6, CRITICAL CARE SERVICES

Practice 6, Report A

Rationale:
A. This choice is incorrect. **99291** is correct for the critical care service, based on time documented. Diagnosis **806.00** (fracture, C1-C4 with unspecified spinal cord injury) is incorrect because there is no documentation of spinal cord injury. Diagnosis **E888.8** is not reported because there is no clear documentation of what happened and the injury was likely the result of a medical condition (syncope) versus an “accident.” **780.09** (other alteration of consciousness) is incorrect because the documentation indicates syncope (**780.2**).

B. This choice is incorrect. **99221** reports an initial hospital service. When critical care is part of the initial visit by the same provider, the work for the admission is “bundled” into the critical care service code and not reported separately. **E888.8** is not reported because there is no clear documentation of what happened, and the injury was likely the result of a medical condition (syncope) versus an “accident.” The remaining diagnoses are correct.

C. **Is the correct answer.** Only **99291** can be assigned because the nonspecific statement of “Total critical care time did exceed 30 minutes” was the only documentation.

ICD-9-CM—**805.04** is the correct code for a closed cervical 4 fracture without any indication of spinal cord injury; **780.2** is correct for the syncope because there is no further information available. An E code is not assigned because the fracture was a result of the fall from the syncope, not an actual accident.

D. This choice is incorrect. **99221** is for an initial hospital service. When critical care is part of the initial visit by the same provider, the work for the admission is “bundled” into the critical care service code and not separately reported. Diagnosis coding is correct.

Practice 6, Report B

Professional Services: **99291** (Evaluation and Management, Critical Care); **780.97** (Change(s) [of], [mental] status NEC), **465.9** (Infection/infective/infected, respiratory, upper [acute] [infectious] NEC), **458.9** (Hypotension), **599.0** (Urosepsis), **412** (Infarct/infarction, myocardium/myocardial, healed or old, currently presenting no symptoms), **V10.51** (History [of], malignant neoplasm, bladder), **V58.61** (Long-term [current] drug use, anticoagulants), **E888.9** (Index to External Causes, Fall/falling, same level NEC), **E849.7** (Index to External Causes, Accident, occurring (at) (in), home)

Rationale: This is a critical care service, which is based on the time spent with the patient, not the usual key components. At the end of the documentation it states that the physician spent 30 minutes of critical care time on the patient. When billing for critical care, the table in the E/M section of your CPT manual is helpful. The table indicates that for 30-74 minutes code **99291** is to be assigned.

ICD-9-CM—The patient presents with an altered level of consciousness, **780.97**. On further testing he was found to have urosepsis, **599.0**, an upper respiratory infection, **465.9**, and hypotension, **458.9**. We are not given the cause of the hypotension but it responded to fluid; therefore, it could have been from the infection or fluid volume. Do not report **796.3** (Hypotension, transient), because it was treated with fluids. The patient also has a history of bladder cancer, **V10.51** and long term use of anticoagulants, **V58.61**. The instructions at the beginning of the E code chapter in the ICD-9-CM direct the coder to assign E codes to identify the cause of the injury. In this case, the patient was at home (**E849.7**) when he fell (**E888.9**).
PRACTICE 7, NURSING FACILITY SERVICES

Practice 7, Report A

Rationale:
A. This choice is incorrect because 296.90 reports an unspecified episodic mood disorder when a bipolar disorder was documented (296.80). 333.82, orofacial dyskinesia should be 333.85 for orofacial dyskinesia due to drugs. The other codes are correct.

B. This choice is incorrect because 99308 is for a subsequent nursing facility service requiring expanded problem focused history and exam with a low MDM. Two of three key components are required and the expanded problem focused history, detailed exam, and moderate MDM documented support a higher level code (99309). Diagnosis 401.9 is incorrect, because the documentation did not indicate unspecified hypertension. 333.82, orofacial dyskinesia should be 333.85 for orofacial dyskinesia due to drugs. The other diagnoses are correct.

C. This choice is incorrect because 99336 is for an established patient service in a domiciliary, rest home, or custodial care setting and this patient is a resident in a nursing home. 296.90 (unspecified episodic mood disorder) is incorrect because a bipolar disorder was documented and is reported with 296.80. 969.3 is incorrect because there is no current “poisoning” from a medication documented. The correct code is 333.85 (tardive dyskinesia, due to drugs). The remaining codes are correct.

D. Is the correct answer. 99309 is correct because the patient is a resident in a nursing home and this is a subsequent service. As a subsequent service, 2 of 3 key components are required to select a level of service. The documentation supports an internal history, a detailed exam, and moderate MDM. 784.0 reports the headaches; 296.80 reports unspecified bipolar disorder; 401.1 reports benign hypertension; 333.85 reports tardive dyskinesia due to drugs and requires the corresponding E code, E939.3, to indicate the cause of condition as adverse effects of antidepressants. Note that the Tabular note under 333.82 (Orofacial dyskinesia) excludes: orofacial dyskinesia due to drugs. Also reported is 788.30 for the urinary incontinence.

Practice 7, Report B

Professional Services: 99308 (Evaluation and Management, Nursing Facility, Subsequent Care); 331.0 (Alzheimer’s, dementia, with behavioral disturbance), 294.11 (Dementia, with behavioral disturbance)

Rationale: The first line of the note states that this is a routine nursing facility service, which indicates this is an established patient. The only element of the HPI is the statement about frequent combative behavior for a level 1 of problem focused HPI. The ROS consisted of constitutional (no fever, chills), cardiovascular (no chest pain), and respiratory (no shortness of breath), and psychiatric (wonders off) for a level 3, or detailed ROS. The PFSH includes past (dementia) for a level 3 or detailed PFSH. The problem focused HPI, detailed ROS and detailed PFSH make this a detailed history.

The examination consisted of only one constitutional element (general appearance—well-developed, well-nourished), so this would qualify as a one 1 OS. Only 2 BAs were examined, the head (normocephalic and atraumatic) and neck (supple). OSs include: respiratory (clear to auscultation) for a total of 4 BA/OS, which constitute a level 2 or expanded problem focused level examination.
The MDM consisted of a level 3 or multiple number of diagnosis/management options (Alzheimer’s, combative behavior, advanced directives), level 2 or minimal or no data to review, and level 2 or low risk decision making (patient clinically stable, one chronic disease).

A problem focused interval history, expanded problem focused examination, and low complexity MDM qualifies as 99308.

ICD-9-CM—The documentation indicates the diagnosis of Alzheimer’s (331.0). The patient is also experiencing behavior disturbances (294.11). The Index indicates 331.0 followed by 294.11 in slanted brackets, indicating that 294.11 is to be reported after 331.0.
### Practice 7, Report B

#### History of Present Illness (HPI)

<table>
<thead>
<tr>
<th>Elements</th>
<th>Documented</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location (site on body)</td>
<td></td>
</tr>
<tr>
<td>Quality (characteristic, throbbing, sharp)</td>
<td></td>
</tr>
<tr>
<td>Severity (L/H or how intense)</td>
<td></td>
</tr>
<tr>
<td>Duration* (how long for problem or episode)</td>
<td>x</td>
</tr>
<tr>
<td>Timing (when it occurs)</td>
<td></td>
</tr>
<tr>
<td>Context (under what circumstances does it occur)</td>
<td></td>
</tr>
<tr>
<td>Modifying factors (what makes it better or worse)</td>
<td></td>
</tr>
<tr>
<td>Associated signs and symptoms (what else is happening when it occurs)</td>
<td></td>
</tr>
</tbody>
</table>

*Duration not as CPT as HPI Element

#### Review of Systems (ROS)

<table>
<thead>
<tr>
<th>Elements</th>
<th>Documented</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constitutional (e.g., weight loss, fever)</td>
<td>x</td>
</tr>
<tr>
<td>Ophthalmologic (eyes)</td>
<td></td>
</tr>
<tr>
<td>Otolaryngologic (ears, nose, mouth, throat)</td>
<td>x</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td></td>
</tr>
<tr>
<td>Respiratory</td>
<td>x</td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td></td>
</tr>
<tr>
<td>Gynecologic</td>
<td></td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td></td>
</tr>
<tr>
<td>Integumentary (skin and/or breasts)</td>
<td></td>
</tr>
<tr>
<td>Neurological</td>
<td></td>
</tr>
<tr>
<td>Psychiatric</td>
<td></td>
</tr>
<tr>
<td>Endocrine</td>
<td></td>
</tr>
<tr>
<td>Hematologic/Lymphatic</td>
<td></td>
</tr>
<tr>
<td>Allergic/Immunologic</td>
<td></td>
</tr>
</tbody>
</table>

#### Past, Family, and/or Local History (PFSH)

<table>
<thead>
<tr>
<th>Elements</th>
<th>Documented</th>
</tr>
</thead>
<tbody>
<tr>
<td>Past illness, operations, injuries, treatments, and current medications</td>
<td></td>
</tr>
<tr>
<td>Family medical history for heredity and risk</td>
<td></td>
</tr>
<tr>
<td>Social activities; both past and present</td>
<td></td>
</tr>
</tbody>
</table>

#### Examination Elements

<table>
<thead>
<tr>
<th>Elements</th>
<th>Documented</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constitutional (OS)</td>
<td></td>
</tr>
<tr>
<td>Blood pressure, sitting</td>
<td></td>
</tr>
<tr>
<td>Blood pressure, lying</td>
<td></td>
</tr>
<tr>
<td>Pulse</td>
<td></td>
</tr>
<tr>
<td>Respirations</td>
<td></td>
</tr>
<tr>
<td>Temperature</td>
<td></td>
</tr>
<tr>
<td>Height</td>
<td></td>
</tr>
<tr>
<td>Weight</td>
<td></td>
</tr>
<tr>
<td>General appearance</td>
<td>x</td>
</tr>
</tbody>
</table>

(Counts only as 1)

#### Body Areas (BA)

<table>
<thead>
<tr>
<th>Elements</th>
<th>Documented</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head (including face)</td>
<td>x</td>
</tr>
<tr>
<td>Neck</td>
<td></td>
</tr>
<tr>
<td>Chest (including breasts and axillae)</td>
<td></td>
</tr>
<tr>
<td>Abdomen</td>
<td></td>
</tr>
<tr>
<td>Genitalia, groin, buttocks</td>
<td></td>
</tr>
<tr>
<td>Back (including spine)</td>
<td></td>
</tr>
<tr>
<td>Each extremity</td>
<td></td>
</tr>
</tbody>
</table>

#### Organ Systems (OS)

<table>
<thead>
<tr>
<th>Elements</th>
<th>Documented</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ophthalmologic (eyes)</td>
<td></td>
</tr>
<tr>
<td>Otolaryngologic (ears, nose, mouth, throat)</td>
<td></td>
</tr>
<tr>
<td>Cardiovascular</td>
<td></td>
</tr>
<tr>
<td>Respiratory</td>
<td>x</td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td></td>
</tr>
<tr>
<td>Gynecologic</td>
<td></td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td></td>
</tr>
<tr>
<td>Integumentary (skin)</td>
<td></td>
</tr>
<tr>
<td>Neurologic</td>
<td></td>
</tr>
<tr>
<td>Psychiatric</td>
<td></td>
</tr>
<tr>
<td>Hematologic/Lymphatic/Immunologic</td>
<td></td>
</tr>
</tbody>
</table>

#### Examination Elements

<table>
<thead>
<tr>
<th>Elements</th>
<th>Documented</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limited to affected BA/OS</td>
<td></td>
</tr>
<tr>
<td>Limited to affected BA/OS &amp; other related OS(s)</td>
<td></td>
</tr>
<tr>
<td>Extended of affected BA(s) &amp; other related OS(s)</td>
<td></td>
</tr>
<tr>
<td>General multisystem</td>
<td></td>
</tr>
</tbody>
</table>

#### MDM Elements

<table>
<thead>
<tr>
<th>Elements</th>
<th>Documented</th>
</tr>
</thead>
<tbody>
<tr>
<td># of Diagnosis/Management Options</td>
<td></td>
</tr>
<tr>
<td>Minimal</td>
<td></td>
</tr>
<tr>
<td>Limited</td>
<td>x</td>
</tr>
<tr>
<td>Multiple</td>
<td></td>
</tr>
<tr>
<td>Extensive</td>
<td></td>
</tr>
</tbody>
</table>

#### Amount and/or Complexity of Data to Review

<table>
<thead>
<tr>
<th>Elements</th>
<th>Documented</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal/None</td>
<td></td>
</tr>
<tr>
<td>Limited</td>
<td>x</td>
</tr>
<tr>
<td>Moderate</td>
<td></td>
</tr>
<tr>
<td>Extensive</td>
<td></td>
</tr>
</tbody>
</table>

#### Risk of Complication or Death if Not Treated

<table>
<thead>
<tr>
<th>Elements</th>
<th>Documented</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td></td>
</tr>
<tr>
<td>Moderate</td>
<td>x</td>
</tr>
<tr>
<td>High</td>
<td></td>
</tr>
</tbody>
</table>

#### MDM

<table>
<thead>
<tr>
<th>Elements</th>
<th>Documented</th>
</tr>
</thead>
<tbody>
<tr>
<td>Straighforward</td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td></td>
</tr>
<tr>
<td>Moderate</td>
<td></td>
</tr>
<tr>
<td>High</td>
<td></td>
</tr>
</tbody>
</table>

#### Number of Key Components: 2 of 3

History: Problem Focused
Examination: Expanded Problem Focused
MDM: Moderate

99308
PRACTICE 8, DOMICILIARY, REST HOME (E.G., BOARDING HOME), OR CUSTODIAL CARE SERVICES, AND DOMICILIARY, REST HOME (E.G., ASSISTED LIVING FACILITY), OR HOME CARE PLAN OVERSIGHT SERVICES (99324-99340)

Practice 8, Report A

Rationale:
A. **This is the correct choice because this is an established patient in a custodial care facility.** The documentation supports an EPF interval history, a PF exam, and low complexity MDM. This category requires 2 out of 3 key elements to assign a code; therefore, the correct code is **99335**.

B. Incorrect choice because **99307** is for an established patient in a nursing facility not a custodial care facility. The diagnosis **307.42** for idiopathic insomnia is incorrect.

C. Incorrect choice because **99347** is for an established patient home service, not a custodial care center. The diagnosis **307.42** for idiopathic insomnia is incorrect.

D. Incorrect diagnosis code of **780.52** because the sleep disturbance noted is not being treated or addressed in the care plan, so it is not reported. The diagnosis correctly reported is a rash (**782.1**). **99325** is incorrect because it is for a new patient and this patient is established.

Practice 8, Report B

**Professional Services:** **99336** (Evaluation and Management, Domiciliary or Rest Home, Established Patient); **599.0** (Infection/infected/infective [urinary] tract NEC), **V44.59** (Status, cystotomy)

Rationale: This service is an established patient service at the rest home where the patient resides. The HPI consists of: location (urinary system), quality (painful), severity (5 out of 10), and associated signs and symptoms (fever, abdominal pain) for a level 4 or comprehensive HPI. The ROS includes: constitutional (eating fair but skipping meals, denies weight loss), cardiovascular (suprapubic catheter due to urinary retention), and respiratory (denies SOB) for a level 3 or detailed ROS. The history consisted of the patient’s past medical history (urinary retention) and social history (resides in a rest home) for a level 4 or complete PFSH. Level selection of history must match all three areas to qualify for level selection. This documentation contained comprehensive HPI, detailed ROS, and a detailed PFSH for level 3 or detailed interval history.

The examination consisted of one constitutional item (vitals and general appearance) which constitutes 1 OS, 5 BAs, including the abdomen and all 4 extremities and 4 OSs, cardiovascular (regular without murmur), respiratory (diminished breath sounds with mild crackles at both bases), integumentary (color is pink), and psychiatric (mildly confused), for a total of 10 BAs/OSs: however, only OSs can count for a comprehensive examination. Recounting without the BAs, there is a total of 5 OSs, making this a level 3 or detailed examination.

The MDM entailed level 3 or multiple diagnosis/management options (new problem), level 2 or minimal data as none were reviewed, and level 3 or moderate risk (prescription drug management). This is a level 3 or moderate MDM.

A detailed interval history, detailed examination, and moderate MDM is assigned **99336**.
The diagnosis is UTI, reported with 599.0. The fever and abdominal pain would not be reported because they are symptoms of the UTI. V44.59 is reported to indicate the status of the suprapubic catheter, because the status is related to the organ system being treated. The Index lists 44.50, which is an unspecified cystostomy. Other cystostomy (V44.59) is correct as we know this is a suprapubic cystostomy.
### Practice 8, Report B

#### HISTORY ELEMENTS

**HISTORY OF PRESENT ILLNESS (HPI)**
1. Location (site on body) [x]
2. Quality (characteristic: throbbing, sharp) [x]
3. Severity (F/U or how intense)
4. Duration* (how long for problem or episode)
5. Timing (when it occurs)
6. Context (under what circumstances does it occur)
7. Modifying factors (what makes it better or worse)
8. Associated signs and symptoms (what else is happening when it occurs)

*Duration not in CPT as HPI Element

**LEVEL 4**

#### REVIEW OF SYSTEMS (ROS)

1. Constitutional (e.g., weight loss, fever)
2. Ophthalmologic (eyes)
3. Otolaryngologic (ears, nose, mouth, throat)
4. Cardiovascular
5. Respiratory [x]
6. Gastrointestinal
7. Genitourinary
8. Musculoskeletal
9. Integumentary (skin and/or breasts)
10. Neurological
11. Psychiatric
12. Endocrine
13. Hematologic/Lymphatic
14. Allergic/Immunologic

**LEVEL 4**

#### PAST, FAMILY, AND/OR SOCIAL HISTORY (PFSH)

1. Past illness, operations, injuries, treatments, and current medications
2. Family medical history for heredity and risk
3. Social activities, both past and present

**LEVEL 4**

#### MDM ELEMENTS

**# OF DIAGNOSIS/MANAGEMENT OPTIONS**
1. Minimal
2. Limited
3. Multiple [x]
4. Extensive

**LEVEL 3**

**AMOUNT AND/OR COMPLEXITY OF DATA TO REVIEW**
1. Minimal/None
2. Limited
3. Moderate
4. Extensive

**LEVEL 3**

**RISK OF COMPLICATION OR DEATH IF NOT TREATED**
1. Minimal
2. Low
3. Moderate
4. High

**LEVEL 3**

#### EXAMINATION ELEMENTS

**CONSTITUTIONAL (OS)**
- Blood pressure, sitting
- Blood pressure, lying
- Respirations
- Temperature
- Weight
- General appearance

*Counts only as 1*

**LEVEL 4**

#### BODY AREAS (BA)

1. Head (including face)
2. Neck
3. Chest (including breasts and axillae)
4. Abdomen
5. Genitalia, groin, buttocks
6. Back (including spine)
7. Extremity

**LEVEL 5**

#### ORGAN SYSTEMS (OS)

1. Ophthalmologic (eyes)
2. Otolaryngologic (ears, nose, mouth, throat)
3. Cardiovascular
4. Respiratory [x]
5. Gastrointestinal
6. Genitourinary
7. Musculoskeletal
8. Integumentary (skin)
9. Neurologic
10. Psychiatric
11. Hematologic/Lymphatic/Immunologic

**LEVEL 4**

#### EXAM LEVEL

<table>
<thead>
<tr>
<th>Level</th>
<th>Problem Focused</th>
<th>Expanded Problem Focused</th>
<th>Detailed</th>
<th>Comprehensive</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Limited to affected BA/OS</td>
<td>Limited to affected BA/OS &amp; other related OSs</td>
<td>Extended 4+</td>
<td>Extended 4+</td>
</tr>
<tr>
<td>2</td>
<td>2-7 limited</td>
<td>2-7 extended</td>
<td>8+</td>
<td></td>
</tr>
</tbody>
</table>

**EXAMINATION LEVEL** 4

### History: Detailed

**Examination:** Comprehensive

**MDM:** Moderate

**Number of Key Components:** 2 of 3

99336
PRACTICE 9, HOME SERVICES

Practice 9, Report A

Rationale:
A. This is an incorrect choice because 99343 is a new patient home visit rather than an established patient home visit. Diagnosis code 491.0 (chronic bronchitis) is incorrect because documentation did not specify acute or chronic. The osteoarthritis (715.90), decubiti of sacrum (707.03), decubiti of hip (707.04) and pitting edema (782.3) were correctly reported.

B. This is an incorrect choice because 99343 is a new patient home visit rather than an established patient home visit. Diagnosis codes are correct based on the documentation in the report as bronchitis (490), osteoarthritis (715.90), and pitting edema (782.3). Multiple decubiti of unspecified site (707.00) is incorrect as sacrum and hip are mentioned as the sites of decubiti.

C. This is the correct choice because 99349 is a home service for an established patient for a detailed history, detailed level examination and moderate MDM. ICD-9-CM: Diagnosis codes are correct based on the documentation in the report as bronchitis (490), osteoarthritis (715.90), decubitus of sacrum (707.03), decubitus of hip (707.04), and pitting edema (782.3).

D. This is an incorrect choice because the bronchitis was not documented as acute or chronic (491.0) and as such should be reported with 490. The osteoarthritis (715.90), and pitting edema (782.3) were correctly reported. Multiple decubiti of unspecified site (707.00) is incorrect as we are told the decubiti are of the sacrum (707.03) and the hip (707.04). 99349 is correct for an established patient home service.

Practice 9, Report B

Professional Services: 99349 (Evaluation and Management, Home Services); 490 (Bronchitis), 428.0 (Failure/failed, heart, congestive), 332.0 (Parkinsonism [primary])

Rationale: This is a home service, which is based on the whether the patient is new or established and the key components.

The HPI consists of 4 elements: location (lung), quality (productive), duration (since Monday), and modifying factor (Robitussin AC). This qualifies as a level 4 or comprehensive HPI. The patient was not able to answer questions for the ROS due to his condition so this would then qualify for a level 4 or comprehensive ROS. The PFSH includes: past (osteoarthritis, Parkinson's) and social (lives at home) for a level 3 or detailed history. This documentation contains extended comprehensive HPI, a comprehensive ROS and a detailed PFSH for a level 3 or detailed interval history.

The examination contains 3 constitutional elements of blood pressure, respirations, and temperature that qualify as 1 OS. The BAs examined are head (normocephalic, atraumatic), and all 4 extremities, for a total of 5 BAs. Only 3 OSs were examined: cardiovascular (RRR), respiratory (few basilar rales, otherwise clear) and gastrointestinal (abdomen benign, no masses or tenderness). The total of 9 BAs/OSs, makes this a comprehensive examination; however, only OSs count towards a comprehensive examination. Recounting without BAs, there are 5 OSs making this a level 3 or detailed examination.

The MDM contains a level 3 or multiple number of diagnosis and management options (CHF, Parkinson's, cough), level 2 or limited data to review (none reviewed) and level 3 or moderate risk (medication management,
management of two or more chronic illnesses). This qualifies as a level 3 or moderate MDM.

The detailed HPI, detailed level examination and moderate MDM make this home visit 99349.

The primary diagnosis for this home service is bronchitis (490). The cough is not reported as according to Section II.A. of the Official Guidelines for Coding and Reporting symptoms (such as the cough) are not reported when a more definitive diagnosis has been established (bronchitis). The patient also has CHF (428.0) and primary Parkinson’s disease (332.0). The diagnosis osteoarthritis (715.90) is not necessarily reported as it was not treated.
**HISTORY ELEMENTS**

**HISTORY OF PRESENT ILLNESS (HPI)**
1. Location (site on body) ?
2. Quality (characteristic: throbbing, sharp) ?
3. Severity (1/10 or how intense) ?
4. Duration* (how long for problem or episode) ?
5. Timing (when it occurs) ?
6. Context (under what circumstances does it occur) ?
7. Modifying factors (what makes it better or worse) ?
8. Associated signs and symptoms (what else is happening when it occurs) ?

*Duration not in CPT as HPI Element

**REVIEW OF SYSTEMS (ROS)**
1. Constitutional (e.g., weight loss, fever) ?
2. Ophthalmologic (eyes) ?
3. Otolaryngologic (ears, nose, mouth, throat) ?
4. Cardiovascular ?
5. Respiratory ?
6. Gastrointestinal ?
7. Genitourinary ?
8. Musculoskeletal ?
9. Integumentary (skin and/or breasts) ?
10. Neurological ?
11. Psychiatric ?
12. Endocrine ?
13. Hematologic/Lymphatic/Immunologic ?

**TOTAL** Unobtainable

**LEVEL** 4

**PAST, FAMILY, AND/OR LOCAL HISTORY (PFH)**
1. Past illness, operations, injuries, treatments, and current medications ?
2. Family medical history for heredity and risk ?
3. Social activities; both past and present ?

**TOTAL** 1

<table>
<thead>
<tr>
<th>History Level</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>HPI</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brief 1-3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expanded Problem Focused</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Detailed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comprehensive</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ROS</td>
<td>None</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>Problem Pertinent</td>
<td>Extended 4+</td>
<td>Complete 10+</td>
<td></td>
</tr>
<tr>
<td>PFH</td>
<td>None</td>
<td>None</td>
<td>Pertinent</td>
<td>Complete 2-3</td>
</tr>
</tbody>
</table>

**MDM ELEMENTS**

**# OF DIAGNOSIS/MANAGEMENT OPTIONS**
1. Minimal
2. Limited
3. Multiple
4. Extensive

**LEVEL** 3

**AMOUNT AND/OR COMPLEXITY OF DATA TO REVIEW**
1. Minimal/None
2. Limited
3. Moderate
4. Extensive

**LEVEL** 3

**RISK OF COMPLICATION OR DEATH IF NOT TREATED**
1. Minimal
2. Low
3. Moderate
4. High

**LEVEL** 3

<table>
<thead>
<tr>
<th>MDM*</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of DX or management options</td>
<td>Minimal</td>
<td>Limited</td>
<td>Multiple</td>
<td>Extensive</td>
</tr>
<tr>
<td>Amount and/or complexity of data</td>
<td>Minimal/None</td>
<td>Limited</td>
<td>Multiple</td>
<td>Extensive</td>
</tr>
<tr>
<td>Risks</td>
<td>Minimal</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
</tr>
</tbody>
</table>

*To qualify for a given type of MDM complexity, 2 of 3 elements in the table must be met or exceeded.

---

**EXAMINATION ELEMENTS**

**Constitutional (OS)**
- Blood pressure, sitting
- Blood pressure, lying
- Pulse
- Respirations
- Temperature
- Height
- Weight
- General appearance

*Counts only as 1* **NUMBER** 1

**Body Areas (BA)**
1. Head (including face) ?
2. Neck
3. Chest (including breasts and axillae) ?
4. Abdomen
5. Genitalia, groin, buttocks
6. Back (including spine)
7. Each extremity

**NUMBER** 6

**Organ Systems (OS)**
1. Ophthalmologic (eyes) ?
2. Otolaryngologic (ears, nose, mouth, throat) ?
3. Cardiovascular ?
4. Respiratory ?
5. Gastrointestinal ?
6. Genitourinary ?
7. Musculoskeletal ?
8. Integumentary (skin) ?
9. Neurologic ?
10. Psychiatric ?
11. Hematologic/Lymphatic/Immunologic ?

**NUMBER** 2

**Exam Level**
1. Problem Focused
2. Expanded Problem Focused
3. Detailed
4. Comprehensive

**General multi-system (OS only)**

<table>
<thead>
<tr>
<th># of OS</th>
<th>1</th>
<th>2-7 limited</th>
<th>2-7 extended</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BA/OS or BA</strong></td>
<td>1</td>
<td>2-7 limited</td>
<td>2-7 extended</td>
</tr>
<tr>
<td><strong>NUMBER</strong></td>
<td>8+</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**EXAMINATION LEVEL** 4

---

History: Detailed
Examination: Comprehensive
MDM: Moderate
Number of Key Components: 2 of 3
99349
PRACTICE 10A, PROLONGED SERVICES WITH OR WITHOUT DIRECT PATIENT CONTACT (99354-99359)

Practice 10A, Report A

Rationale:
A. This is the correct choice because the documentation supported a comprehensive history and exam with a moderate complexity of MDM. As an established patient, 2 of 3 key components are required for determining a level of service, so this service qualifies for 99215. The additional 40 minutes are reported with the prolonged service code 99354, which is direct face-to-face care of a patient in an outpatient setting.

ICD-9-CM—The diagnosis is reported with 403.90, hypertensive kidney disease, even though the report did not state that there was a correlation between the hypertension and kidney disease the guidelines (Section I.C.7.a.3.) direct the coder to assume a causal relationship between the two conditions and report a 403 code rather than 401.9 (hypertension). Also to be reported is the stage of the kidney disease, which in this case is 585.9, unspecified CKD. The history of present illness indicates that the patient was started on an Advair inhaler but by another physician, and there is no documentation that this physician treated the breathing problem, and as such the condition is not reported. V45.89, Other postprocedural status, is correct to report the previous renal artery stenting. This patient also is a diabetic which certainly can impact the renovascular disease. The Index indicates 250.40, [583.81], which instructs you to list 583.81 for diabetic nephropathy after 250.40. The fifth digit “0” is assigned to 250.40 as there is no mention of uncontrolled diabetes. The type of renal failure is already noted. V58.67 could also be reported for long-term insulin use.

B. This is an incorrect choice because the level of service is too low and no prolonged service code is reported. Diagnosis coding is incorrect as the type of renal failure is not noted. Also the diabetes is not reported.

C. This is an incorrect choice because the level of service is too low and the code 99358 is for non-direct face-to-face care. Also incorrect are 401.9 and 585.9 to report the hypertension and chronic kidney disease because according to the guidelines (Section I.C.7.a.3.) the coder is to assign a 403 category code to report kidney disease and renal failure by assuming a causal relationship between the two. The 440.1 is incorrect because the renal artery stenosis has already been stented.

D. This is an incorrect choice because of 401.9 and 585.9 reporting the hypertension and chronic kidney disease. According to the guidelines (Section I.C.7.a.3.) you are to assign a 403 category code to report kidney disease and renal failure by assuming a causal relationship between the two. The V45.89 is correct; however, the diabetes with nephropathy is missing. The CPT coding is correct.
Practice 10A, Report B

**Professional Services:** 99233 (Evaluation and Management, Hospital), 99356 (Evaluation and Management, Prolonged Services), 99357x2 (Evaluation and Management, Prolonged Services); 584.9 (Failure/failed, renal, acute), 599.60 (Uropathy, obstructive), 585.9 (Failure/failed, renal, chronic), 591 (Hydronephrosis), 276.1 (Hyponatremia), 276.6 (Overload, fluid)

**Rationale:** This is a document that represents prolonged service of care. When reporting for prolonged services an E/M code from the accurate subcategory is first selected using the key components of the documentation. The time allotted for that E/M level is subtracted from the total time of the service and the remaining time is reported with a prolonged service code. Prolonged service codes are add-on codes; therefore, never reported alone.

This patient is acutely ill and is being followed for his acute renal failure. There are 4 elements of HPI: location (kidney), quality (worsening), severity (acute), and associated signs and symptoms (bloody urine) for a level 4 or comprehensive HPI. Only two systems were reviewed, cardiovascular (no chest pain) and respiratory (no shortness of breath), for a level 3 or detailed ROS. The documentation included only the past history (chronic renal failure) element of PFSH for a level 3 or detailed PFSH. A comprehensive HPI, detailed ROS, and detailed PFSH qualifies as a level 3 or detailed interval history.

The constitutional examination consisted of 3 elements, blood pressure (lying down), pulse, and temperature, to qualify as 1OS. No BAs were examined. Two OSs were examined, cardiovascular (no edema) and respiratory (lungs are clear), for a total of 2 OSs. The exam performed on this patient entailed 3 OSs and qualifies as a level 2 or expanded problem focused examination.

Level 4 or Extensive diagnosis/management options (acute renal failure, obstructive uropathy, possible dialysis), level 2 or limited data was reviewed (labs), and the level 4 or high risk (need for surgery), which make this level 4 or high MDM.

The detailed HPI, expanded problem focused level examination and high MDM make the subsequent hospital visit 99233 as only 2 of the 3 elements of history, examination and MDM are required.

This code is allotted 35 minutes. At the end of this documentation it states that 2 hours and 25 minutes were spent with the patient. The total in minutes is 145 minutes. Subtract the 35 minutes for the E/M code 99233, which leaves 110 minutes for prolonged services. The prolonged services are categorized by either face-to-face direct contact or without face-to-face direct contact. The direct face-to-face codes are further divided by whether the service took place in an outpatient or inpatient setting. The prolonged service codes that accompany 99233 are 99356 for the first 74 minutes of prolonged time and 99357x2 for the additional 36 minutes. The prolonged Services table in your CPT manual is a good tool to aid in code selection for time.

ICD-9-CM: The patient is being evaluated for acute renal failure (584.9). The other diagnoses are obstructive uropathy (599.60), chronic renal failure (585.9), hydronephrosis (591), hyponatremia (276.1) and fluid overload (276.6). All of these diagnoses would be assigned because all are being treated and each may affect the others.
Practice 10A, Report B

<table>
<thead>
<tr>
<th>HISTORY ELEMENTS</th>
<th>Documented</th>
</tr>
</thead>
<tbody>
<tr>
<td>HISTORY OF PRESENT ILLNESS (HPI)</td>
<td>Documented</td>
</tr>
<tr>
<td>1. Location (site on body)</td>
<td>×</td>
</tr>
<tr>
<td>2. Quality (characteristic: throbbing, sharp)</td>
<td>×</td>
</tr>
<tr>
<td>3. Severity (1/10 or how intense)</td>
<td>×</td>
</tr>
<tr>
<td>4. Duration* (how long for problem or episode)</td>
<td>×</td>
</tr>
<tr>
<td>5. Timing (when it occurs)</td>
<td>×</td>
</tr>
<tr>
<td>6. Content (under what circumstances does it occur)</td>
<td>×</td>
</tr>
<tr>
<td>7. Modifying factors (what makes it better or worse)</td>
<td>×</td>
</tr>
<tr>
<td>8. Associated signs and symptoms (what else is happening when it occurs)</td>
<td>×</td>
</tr>
</tbody>
</table>

*Duration not in CPT as HPI Element

<table>
<thead>
<tr>
<th>TOTAL</th>
<th>LEVEL</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>4</td>
</tr>
</tbody>
</table>

REVIEW OF SYSTEMS (ROS) Documented

| 1. Constitutional (e.g., weight loss, fever) | |
| 2. Ophthalmologic (eyes) | |
| 3. Otolaryngologic (ears, nose, mouth, throat) | |
| 4. Cardiovascular | × |
| 5. Respiratory | × |
| 6. Gastrintestinal | |
| 7. Genitourinary | |
| 8. Musculoskeletal | |
| 9. Integumentary (skin and/or breasts) | |
| 10. Neurological | |
| 11. Psychiatric | |
| 12. Endocrine | |
| 13. Hematologic/Lymphatic | |
| 14. Allergic/Immunologic | |

<table>
<thead>
<tr>
<th>TOTAL</th>
<th>LEVEL</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

PAST, FAMILY, AND/OR SOCIAL HISTORY (PFSH) Documented

| 1. Past illness, operations, injuries, treatments, and current medications | × |
| 2. Family medical history for heredity and risk | |
| 3. Social activities, both past and present | |

<table>
<thead>
<tr>
<th>TOTAL</th>
<th>LEVEL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>History Level</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem Focused</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expanded Problem Focused</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Detailed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comprehensive</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| HPI | Brief | 1-3 | Extended 4+ |	| Extended 4+ |
|-----|-------|------|-------------|-------|
| ROS | None  | Problem 1-3 | Complete 10+ | 2-9 |
| PFSH| None  | None     | Pertinent 1  | 2-3 |

HISTORY LEVEL 3

<table>
<thead>
<tr>
<th>EXAMINATION ELEMENTS</th>
<th>Documented</th>
</tr>
</thead>
<tbody>
<tr>
<td>CONSTITUTIONAL (OS)</td>
<td>Documented</td>
</tr>
<tr>
<td>1. Blood pressure, sitting</td>
<td>×</td>
</tr>
<tr>
<td>2. Blood pressure, lying</td>
<td>×</td>
</tr>
<tr>
<td>3. Pulse</td>
<td>×</td>
</tr>
<tr>
<td>4. Respirations</td>
<td>×</td>
</tr>
<tr>
<td>5. Temperature</td>
<td>×</td>
</tr>
<tr>
<td>6. Height</td>
<td></td>
</tr>
<tr>
<td>7. Weight</td>
<td></td>
</tr>
<tr>
<td>8. General appearance</td>
<td>(Counts only as 1) NUMBER 1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BODY AREAS (BA)</th>
<th>Documented</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Head (including face)</td>
<td></td>
</tr>
<tr>
<td>2. Neck</td>
<td></td>
</tr>
<tr>
<td>3. Chest (including breasts and axillae)</td>
<td></td>
</tr>
<tr>
<td>4. Abdomen</td>
<td></td>
</tr>
<tr>
<td>5. Genitalia, groin, buttocks</td>
<td></td>
</tr>
<tr>
<td>6. Back (including spine)</td>
<td></td>
</tr>
<tr>
<td>7. Extremity</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TOTAL</th>
<th>NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>0</td>
</tr>
</tbody>
</table>

ORGAN SYSTEMS (OS) Documented

| 1. Ophthalmologic (eyes) | |
| 2. Otolaryngologic (ears, nose, mouth, throat) | |
| 3. Cardiovascular | |
| 4. Respiratory | |
| 5. Gastrointestinal | |
| 6. Genitourinary | |
| 7. Musculoskeletal | |
| 8. Integumentary (skin) | |
| 9. Neurologic | |
| 10. Psychiatric | |
| 11. Hematologic/Lymphatic/Immunologic | |

<table>
<thead>
<tr>
<th>TOTAL</th>
<th>NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Exam Level</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem Focused</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expanded Problem Focused</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Detailed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comprehensive</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Limited to affected BA/OS</th>
<th>Limited to affected BA/OS &amp; other related OS(s)</th>
<th>Extended of affected BA(s) &amp; other related OS(s)</th>
<th>General multi-system (OSs only)</th>
</tr>
</thead>
<tbody>
<tr>
<td># of OS or BA</td>
<td>1</td>
<td>2-7 limited</td>
<td>2-7 extended</td>
</tr>
</tbody>
</table>

EXAMINATION LEVEL 3

<table>
<thead>
<tr>
<th>MDM ELEMENTS</th>
<th>Documented</th>
</tr>
</thead>
<tbody>
<tr>
<td># OF DIAGNOSIS/MANAGEMENT OPTIONS</td>
<td>Documented</td>
</tr>
<tr>
<td>1. Minimal</td>
<td></td>
</tr>
<tr>
<td>2. Limited</td>
<td></td>
</tr>
<tr>
<td>3. Multiple</td>
<td></td>
</tr>
<tr>
<td>4. Extensive</td>
<td>×</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LEVEL</th>
<th>4</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>AMOUNT AND/OR COMPLEXITY OF DATA TO REVIEW</th>
<th>Documented</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Minimal/None</td>
<td></td>
</tr>
<tr>
<td>2. Limited</td>
<td>×</td>
</tr>
<tr>
<td>3. Moderate</td>
<td></td>
</tr>
<tr>
<td>4. Extensive</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LEVEL</th>
<th>4</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>RISK OF COMPLICATION OR DEATH IF NOT TREATED</th>
<th>Documented</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Minimal</td>
<td></td>
</tr>
<tr>
<td>2. Low</td>
<td></td>
</tr>
<tr>
<td>3. Moderate</td>
<td></td>
</tr>
<tr>
<td>4. High</td>
<td>×</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LEVEL</th>
<th>6</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>MDM*</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of DX or management options</td>
<td>Minimal</td>
<td>Limited</td>
<td>Multiple</td>
<td>Extensive</td>
</tr>
<tr>
<td>Amount and/or complexity of data</td>
<td>Minimal/None</td>
<td>Limited</td>
<td>Moderate</td>
<td>Extensive</td>
</tr>
<tr>
<td>Risks</td>
<td>Minimal</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MDM LEVEL</th>
<th>4</th>
</tr>
</thead>
</table>

*To qualify for a given type of MDM complexity, 2 of 3 elements in the table must be met or exceeded.

History: Detailed
Examination: Detailed
MDM: High
Number of Key Components: 2 of 3
99233, 99356, 99357 × 2

Copyright © 2010, 2009, 2008, Elsevier Inc. All rights reserved.
PRACTICE 10B, STANDBY SERVICES

Practice 10B, Report A

Rationale:
A. Correct because the total time of standby was 25 minutes. The 6 minutes on the telephone regarding another patient cannot be included in the standby time. Per guidelines, standby time of less than 30 minutes cannot be separately reported.
B. Incorrect because the total time was less than 30 minutes, so no code would be assigned.
C. Incorrect because modifier -80 indicates assistant at surgery and the provider was not scrubbed or assisting in the surgery.
D. Incorrect because modifier -52 cannot be appended to an E/M service and the service cannot be reported as it was less than 30 minutes.

Practice 10B, Report B

Professional Services: 99360 × 3 (Evaluation and Management, Physician Standby Services); 656.81 (Distress, fetal, affecting management of pregnancy or childbirth)

Rationale: This is a document that represents physician standby services. There is only one code in this subcategory and it is reported in units depending on the length of time the physician is standing by. The requirements for this code are as follows, the standby service must be requested by another physician, no face-to-face contact is made with the patient, and the physician standing by cannot be providing care to any other patient during that time. If the standby time is less than 30 minutes, the time is not reported. Unlike some of the other E/M codes, the unit of time for standby services must be a full 30 minutes. It is very important to read and understand the guidelines that precede this subcategory before assigning the code.

This documentation indicates 1 hour and 40 minutes of standby or 100 minutes, requested by the patient’s OB/GYN physician, due to increased fetal distress. 99360 is assigned with 3 units (×3), for 90 minutes of the 100 minutes spent in standby. The extra 10 minutes cannot be reported because it is not a full 30 minutes.

The diagnosis is the reason the attending physician requested the physician to standby. In this case, the standby was requested for fetal distress that was affecting the management of childbirth, 656.81. The fifth digit of “1” is assigned because the physician was present until the patient delivered.
PRACTICE 11A, CASE MANAGEMENT SERVICES (99363-99368)

Practice 11A, Report A

Rationale:
A. This choice is incorrect because V66.7 is for an encounter for palliative care and the patient was not seen during this service. V65.49 is appropriate for counseling the family on the options for care. The remaining diagnosis codes are correct. The CPT code is correct.
B. This choice is incorrect because 99367 is reported for a conference in which neither the patient nor the family are present. Diagnosis codes are correct.
C. This choice is incorrect because 99368 is reported for a team conference in which neither the family nor patient attend and a nonphysician leads the team. V66.7 is incorrect because it is for an encounter for palliative care and the patient was not seen during this service. V65.49 is appropriate for counseling the family on the options for care. The remaining diagnosis codes are correct.
D. This is the correct choice with both the diagnoses and service code correct. ICD-9-CM V65.49 reports consulting, which was the primary reason for the service. The patient’s diagnoses are stomach cancer (primary) 151.9, secondary lung cancer (197.0), congestive heart failure (428.0); and chronic interstitial pneumonia (515).

Practice 11A, Report B

Professional Services: 99367 (Evaluation and Management, Case Management Services); 583.9 (Nephritis), 585.6 (Disease/diseased, renal, end-stage), V49.75 (Absence, leg, below knee), V45.11 (Status, dialysis)

Rationale: Case management is when the physician is responsible for the direct care of the patient and for coordinating the care and needs of the patient with other health care services. 99367 is correct to assign because the time spent was 60 minutes and no family was present. The diagnoses are nephritis (583.9), end stage renal disease (585.6), the patient’s postoperative amputation status (V49.75), and the renal dialysis status (V45.11).

PRACTICE 11B, ANTICOAGULANT MANAGEMENT

Practice 11B, Report A

Rationale:
A. Is correct because it reports a 90-day period of anticoagulant management with 99363 and the minimum of 8 INR measurements was met.
B. This choice is incorrect because although it reports 99363 correctly for the initial 90 days of management, 99364 should not be reported.
C. This choice is incorrect because it reports a subsequent 90 days with 99364 and this patient service was an initial 90 days of management.
D. This choice is incorrect because it reports a subsequent 90 days with 99364 and initial 90 days with 99363.
Practice 11B, Report B

Professional Services: 99364 (Anticoagulant Management); 453.42 (Embolism, vein, lower extremity, deep, acute, distal [lower leg])

Rationale: This code is correct because it reports a subsequent 90 days of anticoagulant management that contained at least 3 INR measurements. Code 453.42 reports deep vein thrombosis of the lower leg.
PRACTICE 12, CARE PLAN OVERSIGHT SERVICES

Practice 12, Report A

Rationale:
A. Incorrect because a medical team conference was not provided. Care Plan Oversight service (99380) is correct. Diagnosis coding is correct.
B. Correct because both the diagnosis and service coding are correct. The physician for whom services are being reported is not the physician in charge of chemotherapy administration: the patient’s gynecologist is overseeing that treatment. This physician is providing a care plan oversight for the patient’s total care. ICD-9-CM: When the patient presents for chemotherapy, the gynecologist would report the chemotherapy encounter code V58.11. The patient’s diagnoses are primary ovarian cancer (183.0), neoplasm-related pain (338.3), and edema (782.3).
C. Incorrect because 99308 is a subsequent nursing facility care service, and in this scenario the provider is managing the plan by telephone and is not present at the facility. The diagnosis coding is correct except for V58.11. This physician is providing a care plan oversight for the patient’s total care. When the patient presents for chemotherapy, the gynecologist would report the chemotherapy encounter code V58.11.
D. Incorrect because the diagnosis for pain management and edema are missing and they should be reported because these conditions are being managed. This physician is providing a care plan oversight for the patient’s total care. When the patient presents for chemotherapy, the gynecologist would report the chemotherapy encounter code V58.11. The CPT code is correct.

Practice 12, Report B

Professional Services: 99378 (Evaluation and Management, Care Plan Oversight Services); 162.5 (Neoplasm, lung, lower lobe, Malignant, Primary), 338.3 (Pain[s], neoplasm related)

Rationale: Care plan oversight services reflect a supervisory role of the physician over the patient’s care. The patient is not present when the physician is performing the service. Codes entail development or revision of a care plan, review of reports of patient status, communication with other health care professionals, and review of any lab or tests that may have been performed. These codes may only be reported once for every 30-day period. Codes are divided by whether the patient is receiving care from a home health agency, hospice, or a nursing facility. The codes are further categorized based on physician time spent in care plan oversight. 99378 is the correct code to report this service because the patient is receiving hospice care and the documented time was longer than 30 minutes. The diagnoses are lower lobe lung cancer (162.5) and pain due to the malignancy (338.3).
PRACTICE 13, PREVENTIVE MEDICINE SERVICES

Practice 13, Report A

Rationale:
A. Correct because this is a yearly physical examination of a 43-year-old established patient. 99396 is a preventive medicine code for an established patient between the ages of 40 and 64 years. ICD-9-CM: The diagnoses are V70.0 (Routine medical exam) and V72.31 (Routine GYN exam) for the health check-up. No other diagnoses are reported because the patient was not treated at this time for her weight gain or depression.

B. Incorrect because 99213 is an E/M code for an office service for an established patient reported for the diagnosis of a new problem or follow-up care of an existing problem, not for yearly physicals. The diagnosis code 783.1, weight gain, is not reported because it was not treated during this evaluation.

C. Incorrect because 99386 is a new patient preventive medicine service and this is an established patient. The diagnoses of weight gain (783.1) and depression (311) are not reported because they were not treated by this physician.

D. Incorrect because the age range for this code is 18-39 years and this patient is 43 years old.

Practice 13, Report B

Professional Services: 99396 (Evaluation and Management, Preventive Services); V70.0 (Checkup, health), V72.31 (Gynecological examination), 305.1 (Abuse, tobacco)

Rationale: Preventive medicine services are for physicals. Codes are selected based on patient age—unlike other E/M codes that are based on time or key components. Codes are further divided by whether the patient is new or established.

This documentation is of a 44-year-old established patient. The correct code for the preventive medicine service is 99396. 99406 is not reported since the physician did not document the amount of time spent discussing the tobacco cessation.

The assessment contains 3 diagnoses, yearly physical performed today, gynecological exam, and tobacco abuse. When coding the diagnosis on preventive examinations the first code assigned would be V70.0 for the health checkup followed by the code to report the gynecological exam. Only code the other diagnoses if there is an indication in the plan that these diagnoses are going to be treated or followed up. The physician is recommending smoking cessation, so the abuse of tobacco, 305.1, could be reported. It is important to familiarize yourself with the guidelines that precede the preventive medicine category because these guidelines explain the requirements for reporting both a preventive medicine code and an E/M service on the same day.
PRACTICE 14, NON-FACE-TO-FACE PHYSICIAN SERVICES; SPECIAL E/M SERVICES; AND OTHER E/M SERVICES

Practice 14, Report A

Rationale:
A. Incorrect because diagnoses 846.8 and E819.9 are for current injuries, rather than late effects. The CPT code is correct because special evaluation management services report basic life and/or disability evaluations or work-related medical disability evaluations. This evaluation is for disability resulting from an automobile accident. The treating physician is performing the evaluation. Diagnosis codes 723.1 (neck pain) and 724.2 (back pain) are correct because these represent the residual effects of the previous injury. 99455 is correct because the evaluation was performed by the treating physician, as indicated by the statement “patient will continue with prescribed pain management regimen.”

B. Incorrect because 99456 is for evaluation by other than treating physician, which was not the case in this scenario. Diagnosis coding is correct except code 338.21 (chronic pain) is missing.

C. Incorrect because 99456 is for evaluation by other than treating physician, which was not the case in this scenario. The diagnoses 846.8 and E819.9 are for current injuries, rather than late effects. Diagnosis codes 723.1 (neck pain) and 724.2 (back pain) are correct because they report the residual effects of previous injury. Code 338.21 (chronic pain).

D. Correct, because 99455 reports the evaluation performed by the treating physician, as indicated by the statement “patient will continue with prescribed pain management regimen.” Diagnosis codes 723.1 (neck pain) and 724.2 (back pain) are correct because they report the residual effects of previous injury. Code 338.21 is assigned to report the chronic pain (see Section I.C.6.a. of the guidelines). Diagnoses 905.7 (Late effect of sprain and strain without mention of tend on injury) and E929.0 (Index to External Causes, Late effect of accident, specified NEC) are for the late effects of previously sustained injury.

Practice 14, Report B

Professional Services: 99455 (Evaluation and Management, Insurance Examination); 354.0 (Syndrome, carpal tunnel); 338.21 (Pain[s], chronic, due to trauma)

Rationale: Special evaluation management services are for basic life and/or disability evaluations or work-related medical disability evaluations. This evaluation is for disability resulting from a work-related injury. The treating physician is performing the evaluation and correctly reporting the service with 99455. The diagnoses are carpal tunnel syndrome (354.0) and chronic pain due to trauma (338.21).
PRACTICE 15, NEWBORN CARE SERVICES

Practice 15, Report A

Rationale:
A. Incorrect because diagnosis V30.1 is for an infant born outside of the hospital. This infant was born in the hospital as evidenced by the exact time of birth noted and the APGAR scores reported. Diagnosis 779.31 is not reported because “disorganized suck” alone in a newborn is not indicative of a feeding disorder. It is noted that once the infant is able to suck, 10–20 cc are taken per feeding. CPT 99463 is correct.
B. Incorrect because 99234 is reported for observation and discharge on the same date. Although the baby was admitted and discharged on the same day, 99234 is incorrect because there is a code for newborn admitted and discharged on the same date, which is more appropriate for the patient involved. Diagnosis V30.1 is incorrect because it is for an infant born outside of the hospital. This infant was born in the hospital as evidenced by the exact time of birth noted and the APGAR scores reported.
C. Incorrect because 99234 is reported for observation and discharge on the same date. Although the baby was admitted and discharged on the same day, 99234 is incorrect because there is a code for newborn admitted and discharged on the same date, which is more appropriate for the patient involved. Diagnosis 779.31 is not reported because “disorganized suck” alone in a newborn is not indicative of a feeding disorder. It is noted that once the infant is able to suck, 10–20 cc are taken per feeding. Diagnosis V30.00 is correct.
D. Correct because 99463 correctly reports the admission and discharge of a normal newborn on the same date.
ICD-9-CM: Diagnosis V30.00 is correct because it reports a single liveborn infant, born in a hospital without mention of cesarean section.

Practice 15, Report B

Professional Services: 99462 (Evaluation and Management, Newborn Care); 767.19 (Birth, injury, scalp)

Rationale: The patient is a normal newborn, born in the hospital with a multiple day stay. CPT 99462 is reported for the subsequent hospital care of the newborn, per day. There are no elements or key components to be considered when assigning this code.
Diagnosis 767.19 is still reported because the condition is re-evaluated on examination (“exam is unchanged”). Note that diagnosis code V30.00 is not reported for services other than the initial admission (see newborn guidelines, Section I.C.15.b).
PRACTICE 16, INPATIENT NEONATAL INTENSIVE CARE SERVICES AND PEDIATRIC AND NEONATAL CRITICAL CARE SERVICES

Practice 16A, Report A

Rationale:
A. Incorrect because the critical care time at the initial facility is reported separately as the report states this was a “critical care patient” and 1 ½ hours was spent with this patient prior to transport. The transport time is not reported correctly as it should be 99479, 99467.
B. Incorrect because the multiple units for 99467 is incorrect.
C. Incorrect because the critical care time at the initial facility is not reported. The transport time is incorrectly reported.
D. Correct. One and one-half hours of critical care time was spent at the initial facility prior to transport. The report states “critical care patient”, therefore the patient was register in the initial facility. Code 99291 reports 30-74 minutes of critical care and 99292 reports additional blocks of time up to 30 minutes. The total initial facility time was 90 minutes. The remaining time (90-75 = 15 minutes) of 15 minutes is reported with 99292. The transport time was 2 hours; therefore, report 99466 (30-74 minutes) and 99467 (75-120 minutes = 45 minutes = 1 unit). Code 99467 represent each additional 30 minutes. Fifteen minutes remain; therefore, the 15 minutes is not reported. The correct answer is 99291, 99292, 99466, 99467.

Practice 16A, Report B

Professional Services: 99466 (Evaluation and Management, Pediatric Interfacility Transport); 99467 × 2 (Evaluation and Management, Pediatric Interfacility Transport); 949.0 (Burn, unspecified), 785.50 (Shock), E899 (Index to External Causes, Burning, burns)

Rationale: This documentation is very vague. You should discuss with the physician the need for more detailed documentation to ensure proper coding and achievement of the highest level of specificity.

This documentation is very vague. You should discuss with the physician the need for more detailed documentation to ensure proper coding

The time given in this documentation is 2 hours and 40 minutes, or 160 minutes. 99466 is reported for the first 30-74 minutes. 99467 is an add-on code and is reported in conjunction with 99466 to report each additional 30 minutes of time after the first 74 minutes. The additional time after the first 74 minutes is 86 minutes or 99467 × 2. The remaining 26 minutes is not reported because it is less than the 30 minutes required. No audit form is needed when assigning codes from this subcategory because the codes are time-based and not based on key components.

This is an 18-month-old who was burned and went into shock. The body area and severity of the burn is not specified in this documentation. Neither is the cause of the burn. The diagnoses are reported as 949.0 (Burn) and shock, 785.50. An E code is assigned to report an unspecified burn, E899.
**Practice 16B, Report A**

**Rationale:**
A. Incorrect because there is no indication that the neonatal intensive care physician was the surgeon. Critical care providers do not generally perform surgical procedures, other than those necessary to maintain the patient's viability, such as intubation.

B. Incorrect because the patient is in the NICU (Neonatal Intensive Care Unit) and vitals are being monitored continuously. This is not a subsequent hospital service reported with 99231. Also incorrect in this selection is the diagnosis code of 764.09, Light for date, because there is no indication of the birthweight. V45.89 reports a surgical status for the hernia repair, when this admission was for the surgery and none of the conditions were documented to be a result of surgery. Code 550.10 to report the inguinal hernia is correct.

C. **This is the correct choice because the infant weighed 4696 grams and is 2 months and 1 week of age.** This was a subsequent care indicated by the title of the report “Progress Note” and the content of the note indicating previous studies and care; therefore, the service is reported with 99480. The service 99480 is appropriate as the infant does not require pediatric critical care per day service; however, he does require intensive observation and monitoring of perfusion.

The patient was admitted for repair of a unilateral incarcerated inguinal hernia (550.10) and developed acute pneumonia (486) and bradycardia (427.89).

D. Incorrect because V45.89 reports a postsurgical status for the hernia repair, when this admission was for the surgery and none of the conditions were documented to be a result of surgery. The remaining codes are correct.

**Practice 16B, Report B**

**Professional Services:** 99479 (Evaluation and Management, Low Birthweight Infant); 765.10 (Premature, birth NEC); 765.26 (Newborn, gestation, 31-32 completed weeks)

**Rationale:** Codes 99478, 99479, and 99480 report physician services on days other than the day of admit, for infants of very low birth weight (VLBW) (infants weighing less than 1500 grams), low birth weight (LBW) (1500-2500 grams), or normal weight (2501-5000 grams) who do not meet the definition of critically ill but still require intensive services. These infants are recovering. Code selection depends on the weight of the infant. The infant in this documentation is 2100 grams with stable respiratory status. The correct code to assign is 99479.

The patient is a premature underweight infant (765.10 with a fifth digit of “0” to represent the birthweight of the infant) delivered at 27 weeks gestation (765.24). The birthweight of the infant is not given; therefore, the 5th digit “0” for unspecified is reported. The current weight is 2100 grams; however, that is 55 days after birth. Coding guidelines for code range 765.xx also indicate to “use additional code for weeks of gestation (765.20-765.29).