

# Evaluation and Management Services

**CASE 1-1****1-1A INITIAL HOSPITAL CARE****1-1B DISCHARGE SUMMARY****CASE 1-1****1-1A INITIAL HOSPITAL CARE**

**Professional Services:** 99221 (Evaluation and Management, Hospital)

**ICD-10-CM DX:** E10.10 (Diabetes, type 1, with, ketoacidosis), J45.909 (Asthma, asthmatic)

**RATIONALE:** The HPI included a total of 6 elements: location (stomach, legs), quality (persistent vomiting), duration (since 5 AM), timing (continued, recurrent emesis), modifying factors (Humalog  $\times$  2, Ultralente), and associated signs and symptoms (confused, cramping in legs, sore throat, abdominal discomfort, emesis), for a level 4 or comprehensive HPI.

The ROS included 10 elements: ophthalmologic (eyes), otolaryngologic (ears and mouth), cardiovascular (cardiac), respiratory (chest), genitourinary, musculoskeletal, neurologic, psychiatric, hematologic, and immunologic (infectious disease), for a level 4 or comprehensive ROS.

All 3 of the PFSH (past, family, social history) elements were reviewed for a level 4 or comprehensive PFSH.

A comprehensive HPI (level 4), comprehensive ROS (level 4), and comprehensive PFSH (level 4) place the history level at a level 4 or comprehensive history.

The examination elements include 4 constitutional items (blood pressure, pulse, respirations, and general appearance [sluggish]), which equals 1 organ system. There were 2 BAs: neck (supple) and chest (symmetrical). There were 6 OSs: ophthalmologic (eyes), otolaryngologic (ears, mouth), cardiovascular (heart and good pulses), respiratory (clear to auscultation), lymphatic (neck and axillary nodes), and gastrointestinal (abdomen, some tenderness). There were 9 BAs/OSs reviewed, which would ordinarily place this examination in the level 4 or comprehensive physical examination, but for a comprehensive level, only the OSs are counted and the BAs are disregarded.

CHAPTER 1, CASE 1-1A

HISTORY ELEMENTS				Documented
<b>HISTORY OF PRESENT ILLNESS (HPI)</b>				
1. Location (site on body)				X
2. Quality (characteristic: throbbing, sharp)				X
3. Severity (1/10 or how intense)				
4. Duration* (how long for problem or episode)				X
5. Timing (when it occurs)				X
6. Context (under what circumstances does it occur)				
7. Modifying factors (what makes it better or worse)				X
8. Associated signs and symptoms (what else is happening when it occurs)				X
*Duration not in CPT as HPI Element	TOTAL			6
	LEVEL			4
<b>REVIEW OF SYSTEMS (ROS)</b>				
1. Constitutional (e.g., weight loss, fever)				
2. Ophthalmologic (eyes)				X
3. Otolaryngologic (ears, nose, mouth, throat)				X
4. Cardiovascular				X
5. Respiratory				X
6. Gastrointestinal				
7. Genitourinary				X
8. Musculoskeletal				X
9. Integumentary (skin and/or breasts)				
10. Neurological				X
11. Psychiatric				X
12. Endocrine				
13. Hematologic/Lymphatic				X
14. Allergic/Immunologic				X
	TOTAL			10
	LEVEL			4
<b>PAST, FAMILY, AND/OR SOCIAL HISTORY (PFSH)</b>				
1. Past illness, operations, injuries, treatments, and current medications				X
2. Family medical history for heredity and risk				X
3. Social activities, both past and present				X
	TOTAL			3
	LEVEL			4
History Level	I	2	3	4
	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
HPI	Brief 1-3	Brief 1-3	Extended 4+	Extended 4+
ROS	None	Problem Pertinent I	Extended 2-9	Complete 10+
PFSH	None	None	Pertinent I	Complete 2-3
	HISTORY LEVEL			4

EXAMINATION ELEMENTS				Documented
<b>CONSTITUTIONAL (OS)</b>				
• Blood pressure, sitting				X
• Blood pressure, lying				
• Pulse				X
• Respirations				X
• Temperature				
• Height				
• Weight				
• General appearance				X
	(Counts as only 1)	NUMBER		1
<b>BODY AREAS (BA)</b>				
1. Head (including face)				
2. Neck				X
3. Chest (including breasts and axillae)				X
4. Abdomen				
5. Genitalia, groin, buttocks				
6. Back (including spine)				
7. Each extremity				
		NUMBER		2
<b>ORGAN SYSTEMS (OS)</b>				
1. Ophthalmologic (eyes)				X
2. Otolaryngologic (ears, nose, mouth, throat)				X
3. Cardiovascular				X
4. Respiratory				X
5. Gastrointestinal				X
6. Genitourinary				
7. Musculoskeletal				
8. Integumentary (skin)				
9. Neurologic				
10. Psychiatric				
11. Hematologic/Lymphatic/Immunologic				X
		NUMBER		6
		TOTAL BA/OS		9(7)
Exam Level	I	2	3	4
	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
	Limited to affected BA/OS	Limited to affected BA/OS & other related OS(s)	Extended of affected BA(s) & other related OS(s)	General multi-system (OSs only)
# of OS or BA	1	2-7 limited	2-7 extended	8+
	EXAMINATION LEVEL			3

MDM ELEMENTS				Documented
# OF DIAGNOSIS/MANAGEMENT OPTIONS				
1. Minimal				
2. Limited				
3. Multiple				
4. Extensive				X
LEVEL				4
AMOUNT AND/OR COMPLEXITY OF DATA TO REVIEW				Documented
1. Minimal/None				X
2. Limited				
3. Moderate				
4. Extensive				
LEVEL				1
RISK OF COMPLICATION OR DEATH IF NOT TREATED				Documented
1. Minimal				
2. Low				
3. Moderate				
4. High				X
LEVEL				4
MDM*	1	2	3	4
	Straightforward	Low	Moderate	High
Number of DX or management options	Minimal	Limited	Multiple	Extensive
Amount and/or complexity of data	Minimal/None	Limited	Moderate	Extensive
Risks	Minimal	Low	Moderate	High
MDM LEVEL				4
*To qualify for a given type of MDM complexity, 2 of 3 elements in the table must be met or exceeded.				

History: Comprehensive  
 Examination: Detailed  
 MDM: High  
 Number of Key Components: 3 of 3  
 99221

*With a total of 7 OSs, this examination is a level 3 or detailed physical examination.*

*The MDM includes extensive diagnoses/management options, minimal/no data to review, and high risk of death or complication if not treated for a level 4 or high MDM. Ketoacidosis is very serious if left untreated, and there is a high risk of death. At the very minimum, there may be compromises to the brain.*

*The diabetes is the reason for the care the patient receives (E10.10). The asthma is reported because it is a significant condition (J45.909). The nausea and vomiting are not coded, as they are symptoms of the diabetic condition that was reported as the primary diagnosis.*

1-1B DISCHARGE SUMMARY \_\_\_\_\_

**Professional Services: 99238** (Evaluation and Management, Hospital, Discharge)

**ICD-10-CM DX: E10.10** (Diabetes, type 1, with, ketoacidosis), **E86.0** (Dehydration), **J45.909** (Asthma)

**RATIONALE:** *The hospital discharge services are based on the time the physician spends in the final discharge of the patient. The service may or may not include an examination of the patient. Since the physician did not indicate the time spent in discharge of the patient, the lowest level of discharge is reported (99238). Physician education is very important to ensure appropriate reimbursement, since only if the physician records the amount of time can the coder accurately assign a discharge code for a higher level discharge service. The time must be documented in the medical record with the beginning and ending time and the time does not have to be consecutive. The physician may spend time on preparation of the final discharge and then return and spend additional time on the discharge documentation.*

*The diagnoses are diabetes, dehydration, and asthma, as indicated in the Discharge Diagnosis section of the report. Nausea and vomiting (R11.2) are integral to the disease process (symptoms) and not reported separately. The dehydration is reported separately as it is a distinct condition.*

## CASE 1-2

## 1-2A EMERGENCY DEPARTMENT SERVICES

## CASE 1-2

## 1-2A EMERGENCY DEPARTMENT SERVICES

**Professional Services: 99284** (Evaluation and Management, Emergency Department)

**ICD-10-CM DX: E86.0** (Dehydration), **J02.9** (Pharyngitis), **E10.9** (Diabetes, type 1), **J45.909** (Asthma), **R11.2** (Nausea, with vomiting)

**RATIONALE:** The HPI included 6 elements: location (pharynx and stomach), severity (not eaten anything for the past 2 days), duration (5 days), timing (frequently [running to the bathroom]), modifying factors (taken all insulin shots), and associated signs and symptoms (fever, chills, cough, headache, blood sugar, unable to eat) for a level 4 or comprehensive HPI. The ROS included 10 elements: ophthalmologic (eyes), otolaryngologic (ears), cardiovascular, respiratory (no shortness of breath or heavy breathing), gastrointestinal, genitourinary, neurologic, psychiatric, hematologic, and immunologic (infectious disease) for a level 4 or comprehensive ROS. All 3 elements of the PFSH were noted for a level 4 or comprehensive PFSH. A comprehensive HPI (level 4), comprehensive ROS (level 4), and comprehensive PFSH (level 4) place this history service at a level 4 or comprehensive.

The examination included 4 constitutional elements of blood pressure, pulse, temperature, and general appearance (appears dehydrated with sunken eyeballs and a flushed face) for 1 organ system. There were 2 body areas of neck (supple) and abdomen (soft, nontender). There were 6 organ systems of ophthalmologic (eyes), otolaryngologic (tongue), respiratory (clear to auscultation), cardiovascular (heart, good pulses), lymphatic (neck nodes), and neurologic (normal reflexes). Note that although the thyroid was examined, the endocrine system is not listed as an examination organ system. The endocrine system is listed as an element of the ROS in the history, but not in the examination portion of the service. The total number of BAs/OSs is 9, which would ordinarily make this a level 4 or comprehensive examination; however, only OSs are counted for the comprehensive level. With a total of 7 OSs, this examination is a level 3 or detailed physical examination.

The MDM contained extensive diagnosis/management options (Type 1 diabetes mellitus that is not controlled, worsening pharyngitis, the new problem of dehydration, stable asthma, and possible ketoacidosis), no data indicated as reviewed, and a high risk to the patient if the condition were left untreated (the diabetes mellitus with complications) for a level 4 or high MDM.

The level of risk is subjective, and some might assign a moderate level of risk rather than a high level of risk to the patient. If a moderate level of risk were assigned, the code would not change from **99284**.

The diagnoses are listed in the order as stated on the report in the Impression section, which is dehydration, pharyngitis, diabetes mellitus, and asthma. According to outpatient coding guidelines, you cannot code suspected conditions as if they exist, so the ketoacidosis cannot be reported. You can report present symptoms of nausea and vomiting, as no clear diagnostic statement has been made about the cause of the nausea and vomiting.

## Coding Case and Auditing Review Answers with Rationales

### CHAPTER 1, CASE 1-2A

HISTORY ELEMENTS				Documented
<b>HISTORY OF PRESENT ILLNESS (HPI)</b>				
1. Location (site on body)				X
2. Quality (characteristic: throbbing, sharp)				X
3. Severity (1/10 or how intense)				X
4. Duration* (how long for problem or episode)				X
5. Timing (when it occurs)				X
6. Context (under what circumstances does it occur)				X
7. Modifying factors (what makes it better or worse)				X
8. Associated signs and symptoms (what else is happening when it occurs)				X
*Duration not in CPT as HPI Element				
TOTAL				6
LEVEL				4
<b>REVIEW OF SYSTEMS (ROS)</b>				Documented
1. Constitutional (e.g., weight loss, fever)				X
2. Ophthalmologic (eyes)				X
3. Otolaryngologic (ears, nose, mouth, throat)				X
4. Cardiovascular				X
5. Respiratory				X
6. Gastrointestinal				X
7. Genitourinary				X
8. Musculoskeletal				X
9. Integumentary (skin and/or breasts)				X
10. Neurological				X
11. Psychiatric				X
12. Endocrine				X
13. Hematologic/Lymphatic				X
14. Allergic/Immunologic				X
TOTAL				10
LEVEL				4
<b>PAST, FAMILY, AND/OR SOCIAL HISTORY (PFSH)</b>				Documented
1. Past illness, operations, injuries, treatments, and current medications				X
2. Family medical history for heredity and risk				X
3. Social activities, both past and present				X
TOTAL				3
LEVEL				4
History Level	1	2	3	4
	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
HPI	Brief 1-3	Brief 1-3	Extended 4+	Extended 4+
ROS	None	Problem Pertinent 1	Extended 2-9	Complete 10+
PFSH	None	None	Pertinent 1	Complete 2-3
HISTORY LEVEL				4

EXAMINATION ELEMENTS				Documented
<b>CONSTITUTIONAL (OS)</b>				
• Blood pressure, sitting				X
• Blood pressure, lying				X
• Pulse				X
• Respirations				X
• Temperature				X
• Height				X
• Weight				X
• General appearance				X
(Counts as only 1)				1
NUMBER				1
<b>BODY AREAS (BA)</b>				Documented
1. Head (including face)				X
2. Neck				X
3. Chest (including breasts and axillae)				X
4. Abdomen				X
5. Genitalia, groin, buttocks				X
6. Back (including spine)				X
7. Each extremity				X
NUMBER				2
<b>ORGAN SYSTEMS (OS)</b>				Documented
1. Ophthalmologic (eyes)				X
2. Otolaryngologic (ears, nose, mouth, throat)				X
3. Cardiovascular				X
4. Respiratory				X
5. Gastrointestinal				X
6. Genitourinary				X
7. Musculoskeletal				X
8. Integumentary (skin)				X
9. Neurologic				X
10. Psychiatric				X
11. Hematologic/Lymphatic/Immunologic				X
NUMBER				6
TOTAL BA/OS				9(7)
Exam Level	1	2	3	4
	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
	Limited to affected BA/OS	Limited to affected BA/OS & other related OS(s)	Extended of affected BA(s) & other related OS(s)	General multi-system (OSs only)
# of OS or BA	1	2-7 limited	2-7 extended	8+
EXAMINATION LEVEL				3

MDM ELEMENTS				Documented
<b># OF DIAGNOSIS/MANAGEMENT OPTIONS</b>				
1. Minimal				
2. Limited				
3. Multiple				X
4. Extensive				X
LEVEL				4
<b>AMOUNT AND/OR COMPLEXITY OF DATA TO REVIEW</b>				Documented
1. Minimal/None				X
2. Limited				X
3. Moderate				X
4. Extensive				X
LEVEL				1
<b>RISK OF COMPLICATION OR DEATH IF NOT TREATED</b>				Documented
1. Minimal				
2. Low				
3. Moderate				
4. High				X
LEVEL				4
MDM*	1	2	3	4
	Straightforward	Low	Moderate	High
Number of DX or management options	Minimal	Limited	Multiple	Extensive
Amount and/or complexity of data	Minimal/None	Limited	Moderate	Extensive
Risks	Minimal	Low	Moderate	High
MDM LEVEL				4
*To qualify for a given type of MDM complexity, 2 of 3 elements in the table must be met or exceeded.				

History: Comprehensive  
Examination: Detailed  
MDM: High

Number of Key Components: 3 of 3

99284

## CASE 1-3

## 1-3A INITIAL HOSPITAL SERVICE

## 1-3B CONSULTATION

## 1-3C RADIOLOGY REPORT

## 1-3D RADIOLOGY REPORT

## CASE 1-3

## 1-3A INITIAL HOSPITAL SERVICE

**Professional Services: 99221** (Evaluation and Management, Hospital)

**ICD-10-CM DX: R10.31** (Pain[s], abdominal, lower, right quadrant), **E10.9** (Diabetes, type 1), **J01.90** (Sinusitis, acute), **J45.909** (Asthma)

**RATIONALE:** The HPI included 5 elements: location (right lower quadrant of abdomen), duration (24-48 hours), modifying factors (nothing has helped make it better or worse), associated signs and symptoms (nausea), and severity (becoming gradually worse) for a level 4 or comprehensive HPI. The ROS included 10 elements: constitutional (she has been in good health), ophthalmologic (E of the HEENT), otolaryngologic (ENT of HEENT), cardiovascular, respiratory, gastrointestinal, genitourinary, musculoskeletal (good range of motion and no gait complications under Extremities), neurologic, and psychiatric for a level 4 or comprehensive ROS. Each of the 3 elements of the PFSH was reviewed for a level 4 or comprehensive PFSH. This is a level 4 or comprehensive history.

During the examination, there were 4 constitutional elements indicated: blood pressure, pulse, respirations, and temperature, which equal 1 organ system. There were 2 BAs examined: head (H in HEENT), abdomen (tenderness, masses). There were 6 OSs examined: ophthalmologic (E in HEENT), otolaryngologic (ENT in HEENT, nose, throat, tongue), cardiovascular (S1 and S2, murmurs, bruits, peripheral pulses), musculoskeletal (range of motion), gastrointestinal (bowel sounds), and respiratory for a total of 9 BAs/OSs examined, which would ordinarily make this a level 4 or comprehensive examination; however, only OSs are counted for the comprehensive level. With a total of 7 OSs, this examination is a level 3 or detailed physical examination.

The MDM had extensive diagnoses/management options as the patient had abdominal pain that was worsening, diabetes, acute sinusitis, and asthma. The amount/complexity of data was minimal as there was review of laboratory data and orders for additional lab tests. The risk is moderate as there is one undiagnosed new problem (abdominal pain) with an uncertain outcome. This is a level 3 or moderate MDM.

The reason for the encounter is abdominal pain, diabetes, acute sinusitis, and asthma as listed on the Assessment section of the report. The abdominal pain is reported rather than the appendicitis as the appendicitis is a “rule out” diagnosis, and outpatient/physician coders do not report “rule out” diagnoses.

Some coders might consider the nausea to be an integral part of abdominal pain, and others would report the nausea with a separate code (R11.0). The migraine was not treated so would not be reported with G43.909.

## Coding Case and Auditing Review Answers with Rationales

### CHAPTER 1, CASE 1-3A

HISTORY ELEMENTS				Documented
<b>HISTORY OF PRESENT ILLNESS (HPI)</b>				
1. Location (site on body)				X
2. Quality (characteristic: throbbing, sharp)				X
3. Severity (1/10 or how intense)				X
4. Duration* (how long for problem or episode)				X
5. Timing (when it occurs)				
6. Context (under what circumstances does it occur)				
7. Modifying factors (what makes it better or worse)				X
8. Associated signs and symptoms (what else is happening when it occurs)				X
*Duration not in CPT as HPI Element	TOTAL			5
	LEVEL			4
<b>REVIEW OF SYSTEMS (ROS)</b>				
1. Constitutional (e.g., weight loss, fever)				X
2. Ophthalmologic (eyes)				X
3. Otolaryngologic (ears, nose, mouth, throat)				X
4. Cardiovascular				X
5. Respiratory				X
6. Gastrointestinal				X
7. Genitourinary				X
8. Musculoskeletal				X
9. Integumentary (skin and/or breasts)				
10. Neurological				X
11. Psychiatric				X
12. Endocrine				
13. Hematologic/Lymphatic				
14. Allergic/Immunologic				
	TOTAL			10
	LEVEL			4
<b>PAST, FAMILY, AND/OR SOCIAL HISTORY (PFSH)</b>				
1. Past illness, operations, injuries, treatments, and current medications				X
2. Family medical history for heredity and risk				X
3. Social activities, both past and present				X
	TOTAL			3
	LEVEL			4
History Level	1	2	3	4
	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
HPI	Brief 1-3	Brief 1-3	Extended 4+	Extended 4+
ROS	None	Problem Pertinent 1	Extended 2-9	Complete 10+
PFSH	None	None	Pertinent 1	Complete 2-3
	HISTORY LEVEL			4

EXAMINATION ELEMENTS				Documented
<b>CONSTITUTIONAL (OS)</b>				
• Blood pressure, sitting				X
• Blood pressure, lying				
• Pulse				X
• Respirations				X
• Temperature				X
• Height				
• Weight				
• General appearance				
	(Counts as only 1)	NUMBER		1
<b>BODY AREAS (BA)</b>				
1. Head (including face)				X
2. Neck				
3. Chest (including breasts and axillae)				
4. Abdomen				X
5. Genitalia, groin, buttocks				
6. Back (including spine)				
7. Each extremity				
		NUMBER		2
<b>ORGAN SYSTEMS (OS)</b>				
1. Ophthalmologic (eyes)				X
2. Otolaryngologic (ears, nose, mouth, throat)				X
3. Cardiovascular				X
4. Respiratory				X
5. Gastrointestinal				X
6. Genitourinary				
7. Musculoskeletal				X
8. Integumentary (skin)				
9. Neurologic				
10. Psychiatric				
11. Hematologic/Lymphatic/Immunologic				
		NUMBER		6
		TOTAL BA/OS		9(7)
Exam Level	1	2	3	4
	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
	Limited to affected BA/OS	Limited to affected BA/OS & other related OS(s)	Extended of affected BA(s) & other related OS(s)	General multi-system (OSs only)
# of OS or BA	1	2-7 limited	2-7 extended	8+
	EXAMINATION LEVEL			3

MDM ELEMENTS				Documented
# OF DIAGNOSIS/MANAGEMENT OPTIONS				
1. Minimal				
2. Limited				
3. Multiple				
4. Extensive				X
LEVEL				4
AMOUNT AND/OR COMPLEXITY OF DATA TO REVIEW				Documented
1. Minimal/None				X
2. Limited				
3. Moderate				
4. Extensive				
LEVEL				1
RISK OF COMPLICATION OR DEATH IF NOT TREATED				Documented
1. Minimal				
2. Low				
3. Moderate				X
4. High				
LEVEL				3
MDM*	1	2	3	4
	Straightforward	Low	Moderate	High
Number of DX or management options	Minimal	Limited	Multiple	Extensive
Amount and/or complexity of data	Minimal/None	Limited	Moderate	Extensive
Risks	Minimal	Low	Moderate	High
MDM LEVEL				3
*To qualify for a given type of MDM complexity, 2 of 3 elements in the table must be met or exceeded.				

History: Comprehensive  
 Examination: Detailed  
 MDM: Moderate  
 Number of Key Components: 3 of 3  
 99221



## 1-3B CONSULTATION

**Professional Services: 99253** (Evaluation and Management, Consultation)**ICD-10-CM DX: E10.9** (Diabetes, type 1), **R10.31** (Pain[s], abdominal, lower, right quadrant)

**RATIONALE:** The HPI contained 4 elements: location (lower right quadrant), duration (1-2 days), associated signs and symptoms (decreased appetite and microalbuminuria), and severity (6/10) for a level 3 or detailed HPI. There were 4 ROS elements as noted in the history portion of the consultation report: constitutional (fever/chills), endocrine (diabetes), gastrointestinal (RLQ pain, no change in bowel habits), and neurologic (migraine headaches) for a level 3 or detailed ROS. The PFSH contained all 3 elements for a level 4 or comprehensive PFSH. This is a detailed history.

The examination included 4 constitutional elements: height, weight, temperature (afebrile), and general appearance (in no acute distress) for the equivalent of 1 organ system. There were 5 BAs because there are four extremities: abdomen (hypertrophy, tenderness) and extremities (unremarkable, counts as 4). There were 3 OSs noted: respiratory (lungs clear), cardiovascular, and gastrointestinal (bowel sounds) for a total of 9 BAs/OSs, which would ordinarily make this a level 4 or comprehensive examination; however, only OSs are counted for the comprehensive level. With a total of 4 OSs, this examination is a level 3 or detailed physical examination.

The MDM included an extensive number of diagnoses or management options (diabetes and abdominal pain), a minimal amount/complexity of data to review (blood sugar, urine, microalbuminuria, and white count), and moderate risk of complication or death to the patient if the condition is not treated (undiagnosed new problem with uncertain behavior), for a level 3 or moderate MDM.

The diagnoses are diabetes and abdominal pain as stated in the Assessment and Plan section of the report. The abdominal pain (R10.31) is reported because appendicitis (K35.9) has not been documented at the time of the visit.

The reason for this service is the first-listed diagnosis, and in this case the diabetes management is the primary reason Dr. Jayco is providing a consultation. In the Assessment and Plan section of the report, the physician also indicates the abdominal pain and discusses this pain in the History section of the report; therefore, the abdominal pain is listed second. The asthma, sinusitis, and migraine headaches mentioned in the Past Medical History section of the report would not usually be reported. If you were to report another one of the conditions, the asthma would be the most significant and would therefore be reported.



## Coding Case and Auditing Review Answers with Rationales

### CHAPTER 1, CASE 1-3B

HISTORY ELEMENTS		Documented		
HISTORY OF PRESENT ILLNESS (HPI)				
1. Location (site on body)		X		
2. Quality (characteristic: throbbing, sharp)				
3. Severity (1/10 or how intense)		X		
4. Duration* (how long for problem or episode)		X		
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)		X		
*Duration not in CPT as HPI Element	TOTAL	4		
	LEVEL	4		
REVIEW OF SYSTEMS (ROS)				
		Documented		
1. Constitutional (e.g., weight loss, fever)		X		
2. Ophthalmologic (eyes)				
3. Otolaryngologic (ears, nose, mouth, throat)				
4. Cardiovascular				
5. Respiratory				
6. Gastrointestinal		X		
7. Genitourinary				
8. Musculoskeletal				
9. Integumentary (skin and/or breasts)				
10. Neurological		X		
11. Psychiatric				
12. Endocrine		X		
13. Hematologic/Lymphatic				
14. Allergic/Immunologic				
	TOTAL	4		
	LEVEL	3		
PAST, FAMILY, AND/OR SOCIAL HISTORY (PFSH)				
		Documented		
1. Past illness, operations, injuries, treatments, and current medications		X		
2. Family medical history for heredity and risk		X		
3. Social activities, both past and present		X		
	TOTAL	3		
	LEVEL	4		
History Level	1	2	3	4
	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
HPI	Brief 1-3	Brief 1-3	Extended 4+	Extended 4+
ROS	None	Problem Pertinent 1	Extended 2-9	Complete 10+
PFSH	None	None	Pertinent 1	Complete 2-3
HISTORY LEVEL				3

EXAMINATION ELEMENTS		Documented		
CONSTITUTIONAL (OS)				
• Blood pressure, sitting				
• Blood pressure, lying				
• Pulse				
• Respirations				
• Temperature		X		
• Height		X		
• Weight		X		
• General appearance		X		
(Counts as only 1) NUMBER		1		
BODY AREAS (BA)				
Documented				
1. Head (including face)				
2. Neck				
3. Chest (including breasts and axillae)				
4. Abdomen		X		
5. Genitalia, groin, buttocks				
6. Back (including spine)				
7. Each extremity		XXXX		
NUMBER		5		
ORGAN SYSTEMS (OS)				
Documented				
1. Ophthalmologic (eyes)				
2. Otolaryngologic (ears, nose, mouth, throat)				
3. Cardiovascular		X		
4. Respiratory		X		
5. Gastrointestinal		X		
6. Genitourinary				
7. Musculoskeletal				
8. Integumentary (skin)				
9. Neurologic				
10. Psychiatric				
11. Hematologic/Lymphatic/Immunologic				
NUMBER		3		
TOTAL BA/OS		9(4)		
Exam Level	1	2	3	4
	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
	Limited to affected BA/OS	Limited to affected BA/OS & other related OS(s)	Extended of affected BA(s) & other related OS(s)	General multi-system (OSs only)
# of OS or BA	1	2-7 limited	2-7 extended	8+
EXAMINATION LEVEL				3

MDM ELEMENTS		Documented		
# OF DIAGNOSIS/MANAGEMENT OPTIONS				
1. Minimal				
2. Limited				
3. Multiple				
4. Extensive		X		
	LEVEL	4		
AMOUNT AND/OR COMPLEXITY OF DATA TO REVIEW		Documented		
1. Minimal/None		X		
2. Limited				
3. Moderate				
4. Extensive				
	LEVEL	I		
RISK OF COMPLICATION OR DEATH IF NOT TREATED		Documented		
1. Minimal				
2. Low				
3. Moderate		X		
4. High				
	LEVEL	3		
MDM*	I	2	3	4
	Straightforward	Low	Moderate	High
Number of DX or management options	Minimal	Limited	Multiple	Extensive
Amount and/or complexity of data	Minimal/None	Limited	Moderate	Extensive
Risks	Minimal	Low	Moderate	High
MDM LEVEL				3
*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: Moderate  
 Number of Key Components: 3 of 3  
 99253

1-3C RADIOLOGY REPORT \_\_\_\_\_

**Professional Services: 76705-26** (Ultrasound, abdomen)

**ICD-10-CM DX: R10.31** (Pain[s], abdominal, lower, right quadrant)

**RATIONALE:** The code description for 76705 indicates that the service is for the abdomen and is limited to a single organ, quadrant, or is a follow-up service. This ultrasound is of a single quadrant (right lower quadrant [RLQ]). Modifier -26 is added to the radiology code to indicate that only the professional portion of the service is being reported.

The diagnosis is as stated in the first sentence of the report (RLQ pain) (R10.31) because no definitive diagnosis was made at the time by the radiologist.

1-3D RADIOLOGY REPORT \_\_\_\_\_

**Professional Services: 71020-26** (X-Ray, Chest)

**ICD-10-CM DX: R05** (Cough), **R50.9** (Fever)

**RATIONALE:** The Radiology Report indicates that the x-ray was a posterior-anterior (PA) and lateral of the chest, which is a two-view x-ray. PA indicates that the patient's back (posterior) was closest to the machine and the beam travels through the patient from back to front. Modifier -26 is added to the radiology code to indicate that only the professional portion of the service is being reported.

The diagnosis is as listed in the Indications section of the report as cough (R05) and fever (R50.9).

## CASE 1-4

### 1-4A INITIAL HOSPITAL CARE

#### CASE 1-4

##### 1-4A INITIAL HOSPITAL CARE

**Professional Services:** 99223 (Evaluation and Management, Hospital)

**ICD-10-CM DX:** K85.90 (Pancreatitis), R06.02 (Shortness, breath)

**RATIONALE:** There are 7 HPI elements: location (esophagus as evidenced by the chief complaint dyspepsia/GERD [gastro-esophageal reflux disease]), duration (2 months), context (worse since removal of proton pump inhibitor and Prevacid), modifying factor (more predominant on exertion and medications are not working as previously), timing (daytime [somnolence]), severity (mild [fluid gain] and worsening [symptoms]), and associated signs and symptoms (sleep issues, somnolence or drowsiness, shortness of breath, and fatigue) for a level 4 or comprehensive HPI. The ROS included 10 elements: constitutional (weight gain), ophthalmologic (vision is intact), otolaryngologic (hearing is gone in right ear and diminished some in left), cardiovascular (denies any type of chest pain of a cardiac nature), respiratory (some shortness of breath), gastrointestinal (swallowing, dyspepsia, etc.), genitourinary (no dysuria or polyuria, occasional nocturia), musculoskeletal (no aches or pains in the extremities), neurologic (no worsening of headaches, no change in mentation [thinking abilities]), and psychiatric (sleep pattern disturbed) for a level 4 or comprehensive ROS. All 3 elements of the PFSH were addressed for a level 4 or comprehensive PFSH. This is a comprehensive history.

There were 13 elements examined during the physical examination: 7 constitutional elements of blood pressure, pulse, respiration, temperature, height, weight, and general appearance (slightly pale, no apparent distress), which equals 1 organ system. There were 3 BAs reviewed: head (H in HEENT; negative for deformity), neck (soft, supple), and abdomen (round obese, tenderness). There were 9 OSs examined: ophthalmologic (pupils equal), otolaryngologic (right tympanic membrane, oropharynx, nasal and oral mucosa), cardiovascular (cardiac and edema lower extremities), respiratory (wheezes and crackles), gastrointestinal (bowel sounds, stool, rectal exam), genitourinary (normal genitalia, prostate), lymphatic (lymphadenopathy), neurologic (cranial nerve, sensation intact), and integumentary (skin warm and dry) for a total of 13 elements, which would ordinarily make this a level 4 comprehensive examination; however, only the OSs are counted for the comprehensive level. This service still has 9 OSs and 1 constitutional element (which counts as 1 OS); therefore, this is a comprehensive service.

The MDM is a level 4 or high based on the number of diagnoses/management options being extensive. The amount and complexity of data are extensive as multiple laboratory results were indicated, an echo was ordered, and the doctor independently viewed the chest x-ray and abdominal ultrasound images. The risk to the patient if the condition is left untreated is high.

The service provided to the patient at the clinic is bundled into the hospital admission.

The diagnosis is as stated in the Plan section of the report as pancreatitis (K85.90) and shortness of breath (R06.02).

CHAPTER 1, CASE 1-4A

HISTORY ELEMENTS				Documented
<b>HISTORY OF PRESENT ILLNESS (HPI)</b>				
1. Location (site on body)				X
2. Quality (characteristic: throbbing, sharp)				X
3. Severity (1/10 or how intense)				X
4. Duration* (how long for problem or episode)				X
5. Timing (when it occurs)				X
6. Context (under what circumstances does it occur)				X
7. Modifying factors (what makes it better or worse)				X
8. Associated signs and symptoms (what else is happening when it occurs)				X
*Duration not in CPT as HPI Element	TOTAL			7
	LEVEL			4
<b>REVIEW OF SYSTEMS (ROS)</b>				
1. Constitutional (e.g., weight loss, fever)				X
2. Ophthalmologic (eyes)				X
3. Otolaryngologic (ears, nose, mouth, throat)				X
4. Cardiovascular				X
5. Respiratory				X
6. Gastrointestinal				X
7. Genitourinary				X
8. Musculoskeletal				X
9. Integumentary (skin and/or breasts)				
10. Neurological				X
11. Psychiatric				X
12. Endocrine				
13. Hematologic/Lymphatic				
14. Allergic/Immunologic				
	TOTAL			10
	LEVEL			4
<b>PAST, FAMILY, AND/OR SOCIAL HISTORY (PFSH)</b>				
1. Past illness, operations, injuries, treatments, and current medications				X
2. Family medical history for heredity and risk				X
3. Social activities, both past and present				X
	TOTAL			3
	LEVEL			4
History Level	1	2	3	4
	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
HPI	Brief 1-3	Brief 1-3	Extended 4+	Extended 4+
ROS	None	Problem Pertinent 1	Extended 2-9	Complete 10+
PFSH	None	None	Pertinent 1	Complete 2-3
	HISTORY LEVEL			4

EXAMINATION ELEMENTS				Documented
<b>CONSTITUTIONAL (OS)</b>				
• Blood pressure, sitting				X
• Blood pressure, lying				
• Pulse				X
• Respirations				X
• Temperature				X
• Height				X
• Weight				X
• General appearance				X
	(Counts as only 1)	NUMBER		1
<b>BODY AREAS (BA)</b>				
1. Head (including face)				X
2. Neck				X
3. Chest (including breasts and axillae)				
4. Abdomen				X
5. Genitalia, groin, buttocks				
6. Back (including spine)				
7. Each extremity				
		NUMBER		3
<b>ORGAN SYSTEMS (OS)</b>				
1. Ophthalmologic (eyes)				X
2. Otolaryngologic (ears, nose, mouth, throat)				X
3. Cardiovascular				X
4. Respiratory				X
5. Gastrointestinal				X
6. Genitourinary				X
7. Musculoskeletal				
8. Integumentary (skin)				X
9. Neurologic				X
10. Psychiatric				
11. Hematologic/Lymphatic/Immunologic				X
		NUMBER		9
		TOTAL BA/OS		13(10)
Exam Level	1	2	3	4
	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
	Limited to affected BA/OS	Limited to affected BA/OS & other related OS(s)	Extended of affected BA(s) & other related OS(s)	General multi-system (OSs only)
# of OS or BA	1	2-7 limited	2-7 extended	8+
	EXAMINATION LEVEL			4

MDM ELEMENTS				Documented
# OF DIAGNOSIS/MANAGEMENT OPTIONS				
1. Minimal				
2. Limited				
3. Multiple				
4. Extensive				X
LEVEL				4
AMOUNT AND/OR COMPLEXITY OF DATA TO REVIEW				Documented
1. Minimal/None				
2. Limited				
3. Moderate				
4. Extensive				X
LEVEL				4
RISK OF COMPLICATION OR DEATH IF NOT TREATED				Documented
1. Minimal				
2. Low				
3. Moderate				
4. High				X
LEVEL				4
MDM*	1	2	3	4
	Straightforward	Low	Moderate	High
Number of DX or management options	Minimal	Limited	Multiple	Extensive
Amount and/or complexity of data	Minimal/None	Limited	Moderate	Extensive
Risks	Minimal	Low	Moderate	High
MDM LEVEL				4
*To qualify for a given type of MDM complexity, 2 of 3 elements in the table must be met or exceeded.				

History: Comprehensive  
 Examination: Comprehensive  
 MDM: High  
 Number of Key Components: 3 of 3  
 99223

**CASE 1-5**  
**1-5A INITIAL HOSPITAL CARE**  
**1-5B PROGRESS REPORT**

**CASE 1-5****1-5A INITIAL HOSPITAL CARE**

**Professional Services:** 99223 (Evaluation and Management, Hospital), 99356 (Prolonged service, inpatient) or 99291 (Critical Care Services), 99292 x 3 (Critical Care Services)

**ICD-10-CM DX:** R00.1 (Bradycardia), T46.0X5A (Table of Drugs and Chemicals, Digoxin, External Cause [T-code], Adverse Effect), T46.5X5A (Table of Drugs and Chemicals, Antihypertensive drug NEC, External Cause [T-code], Adverse Effect), D64.9 (Anemia), I48.91 (Fibrillation, atrial or auricular [established])

**RATIONALE:** This history is being taken under urgent conditions, making it an automatic level 4 or comprehensive HPI. The HPI contains 5 elements of location (chest), severity (heart rate of 40-50 indicates the severity and significant hypotension), associated signs and symptoms (weakness, hypotension, and some diaphoresis), duration (May 20), and context (combination of medications) for a level 4 or comprehensive HPI. The ROS contains 13 elements as stated in the report: constitutional, integumentary (skin), ophthalmologic (eyes), otolaryngologic (ENT), lymphatic (lymph nodes), neurologic, psychiatric, respiratory, cardiovascular, gastrointestinal, genitourinary, musculoskeletal, hematologic (counted with lymphatic as 1 OS), and endocrine (endocrinologic) for a level 4 or complete ROS. All 3 of the PFSH were documented for a level 4 or complete PFSH. This is a level 4 or comprehensive history.

The examination elements are 4 constitutional elements of blood pressure, pulse, respiration, temperature (afebrile), which equals 1 organ system. There were 8 BAs documented of head (normocephalic), neck (supple), chest (symmetrical), extremities (arthritic changes, counts as 4), and abdomen (soft, nontender). There were 7 OSs documented: ophthalmologic (conjunctivae and sclerae), otolaryngologic (tongue, mouth, pharynx), cardiovascular (S1, S2, S3, S4, rhythm, pulses are fair), respiratory (no retractions, rhonchi, crackles), gastrointestinal (bowel sounds), musculoskeletal (arthritic changes), and lymphatic (lymphadenopathy) for a total of 16 BAs/OSs; however, only OSs count when calculating a comprehensive level, so the BAs do not count. There were 7 OSs and 1 constitutional element, which counts as 1 OS, for a total of 8 OSs. This service, even without the BAs, is still a level 4 or comprehensive examination.

The MDM included an extensive number of diagnoses/management options (bradycardia is a new problem and tests have been ordered), extensive amount and complexity of data (labs, 2D echo, and old records will be reviewed), and a high risk to the patient. This is a level 4 or high MDM. The typical time for initial hospital care code 99223 is 70 minutes. The time spent with this patient was 2 hours and 20 minutes (140 minutes). Add-on code 99356 is reported for the first hour of prolonged service beyond the typical time for unit/floor time. The notes state "We will continue to follow up on this patient from the critical care standpoint." If critical care was chosen for this service, report 99291, 99292 x 3 as indicated in the critical care chart for 140 minutes.

The diagnosis is listed in the Assessment/Plan section of the report as bradycardia due to medications.

ICD-10-CM Official Guidelines for Coding and Reporting, Section I.C.19.5.a., state to assign the appropriate code for the nature of the adverse effect followed by the code for the adverse effect of the drug (T36-T50). The codes would be listed R00.1 (bradycardia) for the manifestation, followed by the codes for the drugs which caused the adverse effect, T46.0X5A, T46.5X5A, as well as D64.9 (anemia) and I48.91 (atrial fibrillation) for the additional issues that were being treated.

CHAPTER 1, CASE 1-5A

HISTORY ELEMENTS				Documented
<b>HISTORY OF PRESENT ILLNESS (HPI)</b>				
1. Location (site on body)				X
2. Quality (characteristic: throbbing, sharp)				X
3. Severity (1/10 or how intense)				X
4. Duration* (how long for problem or episode)				X
5. Timing (when it occurs)				
6. Context (under what circumstances does it occur)				X
7. Modifying factors (what makes it better or worse)				
8. Associated signs and symptoms (what else is happening when it occurs)				X
*Duration not in CPT as HPI Element	TOTAL			5
	LEVEL			4
<b>REVIEW OF SYSTEMS (ROS)</b>				
1. Constitutional (e.g., weight loss, fever)				X
2. Ophthalmologic (eyes)				X
3. Otolaryngologic (ears, nose, mouth, throat)				X
4. Cardiovascular				X
5. Respiratory				X
6. Gastrointestinal				X
7. Genitourinary				X
8. Musculoskeletal				X
9. Integumentary (skin and/or breasts)				X
10. Neurological				X
11. Psychiatric				X
12. Endocrine				X
13. Hematologic/Lymphatic				X
14. Allergic/Immunologic				X
	TOTAL			13
	LEVEL			4
<b>PAST, FAMILY, AND/OR SOCIAL HISTORY (PFSH)</b>				
1. Past illness, operations, injuries, treatments, and current medications				X
2. Family medical history for heredity and risk				X
3. Social activities, both past and present				X
	TOTAL			3
	LEVEL			4
History Level	1	2	3	4
	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
HPI	Brief 1-3	Brief 1-3	Extended 4+	Extended 4+
ROS	None	Problem Pertinent 1	Extended 2-9	Complete 10+
PFSH	None	None	Pertinent 1	Complete 2-3
	HISTORY LEVEL			4

EXAMINATION ELEMENTS				Documented
<b>CONSTITUTIONAL (OS)</b>				
• Blood pressure, sitting				
• Blood pressure, lying				X
• Pulse				X
• Respirations				X
• Temperature				X
• Height				
• Weight				
• General appearance				
	(Counts as only 1)	NUMBER		1
<b>BODY AREAS (BA)</b>				
1. Head (including face)				X
2. Neck				X
3. Chest (including breasts and axillae)				X
4. Abdomen				X
5. Genitalia, groin, buttocks				
6. Back (including spine)				
7. Each extremity				XXXX
		NUMBER		8
<b>ORGAN SYSTEMS (OS)</b>				
1. Ophthalmologic (eyes)				X
2. Otolaryngologic (ears, nose, mouth, throat)				X
3. Cardiovascular				X
4. Respiratory				X
5. Gastrointestinal				X
6. Genitourinary				
7. Musculoskeletal				X
8. Integumentary (skin)				
9. Neurologic				
10. Psychiatric				
11. Hematologic/Lymphatic/Immunologic				X
		NUMBER		7
		TOTAL BA/OS		16(8)
Exam Level	1	2	3	4
	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
	Limited to affected BA/OS	Limited to affected BA/OS & other related OS(s)	Extended of affected BA(s) & other related OS(s)	General multi-system (OSs only)
# of OS or BA	1	2-7 limited	2-7 extended	8+
	EXAMINATION LEVEL			4

MDM ELEMENTS				Documented
# OF DIAGNOSIS/MANAGEMENT OPTIONS				
1. Minimal				
2. Limited				
3. Multiple				
4. Extensive				X
LEVEL				4
AMOUNT AND/OR COMPLEXITY OF DATA TO REVIEW				Documented
1. Minimal/None				
2. Limited				
3. Moderate				
4. Extensive				X
LEVEL				4
RISK OF COMPLICATION OR DEATH IF NOT TREATED				Documented
1. Minimal				
2. Low				
3. Moderate				
4. High				X
LEVEL				4
MDM*	1	2	3	4
	Straightforward	Low	Moderate	High
Number of DX or management options	Minimal	Limited	Multiple	Extensive
Amount and/or complexity of data	Minimal/None	Limited	Moderate	Extensive
Risks	Minimal	Low	Moderate	High
MDM LEVEL				4
*To qualify for a given type of MDM complexity, 2 of 3 elements in the table must be met or exceeded.				

History: Comprehensive  
Examination: Comprehensive  
MDM: High

Number of Key Components: 3 of 3

99223, 99356 or 99291, 99292 x 3

## 1-5B PROGRESS REPORT

**Professional Services: 99233** (Evaluation and Management, Hospital)

**ICD-10-CM DX: R00.1** (Bradycardia), **T46.0X5A** (Table of Drugs and Chemicals, Digoxin, External Cause [T-code], Adverse Effect), **T46.5X5A** (Table of Drugs and Chemicals, Antihypertensive drug NEC, External Cause [T-code], Adverse Effect), **D64.9** (Anemia), **I48.91** (Fibrillation, atrial or auricular)

**RATIONALE:** Subsequent hospital care includes the review of the medical record and any diagnostic studies that have been done since the last visit. The physician gathers information about any changes in the patient's status from the documentation in the medical record and from the patient. The HPI included quality (feels ... better), associated signs and symptoms (nausea), for a level 2 or expanded problem focused HPI. The ROS included 4 elements of cardiovascular (no palpitations, hemodynamically stable), respiratory (shortness of breath), gastrointestinal (vomiting, diarrhea, constipation), and genitourinary (no urgency, frequency, dysuria), which is a level 3 or detailed ROS. The PFSH are not reviewed, as this information is documented in the medical record from the initial admission but no PFSH is required for subsequent hospital visits. This history is a level 2 or expanded problem focused.

There were 4 constitutional elements reviewed of blood pressure, pulse, respiration, and temperature for 1 organ system. There were 8 BAs examined: head (normocephalic), neck (supple), chest (symmetrical), extremities (arthritic changes, counts as 4), and abdomen (soft, nontender). There were 6 OSs examined: ophthalmologic (conjunctivae, sclerae), otolaryngologic (no nasal discharge, oropharynx), cardiovascular (S1 and S2, pulses good), respiratory (rhonchi, crackles), gastrointestinal (bowel sounds), and lymphatic (lymphadenopathy) for a total of 15 BAs/OSs, which would ordinarily make this a level 4 or comprehensive examination; however, only OSs are counted for the comprehensive level. With a total of 7 OSs, this examination is a level 3 or detailed physical examination.

The MDM is high as it contained extensive diagnosis/management options as the bradycardia is a new problem plus she has atrial fibrillation plus anemia. The data were limited with a review of labs and ECG. The risk is high as this illness presents a threat to life or bodily function.

Only 2 of the 3 key components need to be met to assign a subsequent hospital visit code, so with a comprehensive examination and a high level of MDM, 99233 can be assigned to this service.

Report 1-5B is a good example of the type of report that does not contain all of the diagnoses within the Impression/Plan section of the report. Again, you must focus on the primary reason this service is being provided to this patient. Remember that you only would have this one progress report available to you when the service is coded. According to the Impression/Plan section, the patient has bradycardia due to previously prescribed medications. It is not until the entire report is read that the additional diagnoses of atrial fibrillation (second to last sentence of the Physical Examination section) and the statement that "Her anemia is improving" (last sentence of the Physical Examination section) are found. Both the atrial fibrillation and anemia are to be reported. There is a mention of nausea in the first line of the report, which could be reported with (R11.0), although the physician made no mention of a treatment for the condition, nor correlated it to any current condition.



## CHAPTER 1, CASE 1-5B

HISTORY ELEMENTS				Documented
<b>HISTORY OF PRESENT ILLNESS (HPI)</b>				
1. Location (site on body)				
2. Quality (characteristic: throbbing, sharp)				X
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)				X
*Duration not in CPT as HPI Element	TOTAL			2
	LEVEL			2
<b>REVIEW OF SYSTEMS (ROS)</b>				
1. Constitutional (e.g., weight loss, fever)				
2. Ophthalmologic (eyes)				
3. Otolaryngologic (ears, nose, mouth, throat)				
4. Cardiovascular				X
5. Respiratory				X
6. Gastrointestinal				X
7. Genitourinary				X
8. Musculoskeletal				
9. Integumentary (skin and/or breasts)				
10. Neurological				
11. Psychiatric				
12. Endocrine				
13. Hematologic/Lymphatic				
14. Allergic/Immunologic				
	TOTAL			4
	LEVEL			3
<b>PAST, FAMILY, AND/OR SOCIAL HISTORY (PFSH)</b>				
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			0
	LEVEL			2
History Level	1	2	3	4
	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
HPI	Brief 1-3	Brief 1-3	Extended 4+	Extended 4+
ROS	None	Problem Pertinent 1	Extended 2-9	Complete 10+
PFSH	None	None	Pertinent 1	Complete 2-3
	HISTORY LEVEL			2

EXAMINATION ELEMENTS				Documented
<b>CONSTITUTIONAL (OS)</b>				
• Blood pressure, sitting				
• Blood pressure, lying				X
• Pulse				X
• Respirations				X
• Temperature				X
• Height				
• Weight				
• General appearance				
	(Counts as only 1)	NUMBER		1
<b>BODY AREAS (BA)</b>				
1. Head (including face)				X
2. Neck				X
3. Chest (including breasts and axillae)				X
4. Abdomen				X
5. Genitalia, groin, buttocks				
6. Back (including spine)				
7. Each extremity				XXXX
		NUMBER		8
<b>ORGAN SYSTEMS (OS)</b>				
1. Ophthalmologic (eyes)				X
2. Otolaryngologic (ears, nose, mouth, throat)				X
3. Cardiovascular				X
4. Respiratory				X
5. Gastrointestinal				X
6. Genitourinary				
7. Musculoskeletal				
8. Integumentary (skin)				
9. Neurologic				
10. Psychiatric				
11. Hematologic/Lymphatic/Immunologic				X
		NUMBER		6
		TOTAL BA/OS		15(7)
Exam Level	1	2	3	4
	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
	Limited to affected BA/OS	Limited to affected BA/OS & other related OS(s)	Extended of affected BA(s) & other related OS(s)	General multi-system (OSs only)
# of OS or BA	1	2-7 limited	2-7 extended	8+
	EXAMINATION LEVEL			3

MDM ELEMENTS				Documented
# OF DIAGNOSIS/MANAGEMENT OPTIONS				
1. Minimal				
2. Limited				
3. Multiple				
4. Extensive				X
LEVEL				4
AMOUNT AND/OR COMPLEXITY OF DATA TO REVIEW				Documented
1. Minimal/None				
2. Limited				X
3. Moderate				
4. Extensive				
LEVEL				2
RISK OF COMPLICATION OR DEATH IF NOT TREATED				Documented
1. Minimal				
2. Low				
3. Moderate				
4. High				X
LEVEL				4
MDM*	1	2	3	4
	Straightforward	Low	Moderate	High
Number of DX or management options	Minimal	Limited	Multiple	Extensive
Amount and/or complexity of data	Minimal/None	Limited	Moderate	Extensive
Risks	Minimal	Low	Moderate	High
MDM LEVEL				4
*To qualify for a given type of MDM complexity, 2 of 3 elements in the table must be met or exceeded.				

History: Expanded Problem Focused  
 Examination: Detailed  
 MDM: High  
 Number of Key Components: 2 of 3  
 99233

## CASE 1-6

### 1-6A PROGRESS REPORT

### CASE 1-6

#### 1-6A PROGRESS REPORT

**Professional Services:** 99232 (Evaluation and Management, Hospital)

**ICD-10-CM DX:** R10.9 (Pain[s], abdominal), E78.1 (Hypertriglyceridemia, essential), H92.02 (Pain[s], ear)

**RATIONALE:** The HPI includes the location (left ear pain) and modifying factor (started on antibiotic) for 2 elements or expanded problem focused HPI. There are 3 elements included in the ROS: otolaryngologic (ear pain), respiratory (not in any form of respiratory distress), and gastrointestinal (no dyspepsia) for a level 3 or detailed ROS. There is a statement related to the patient appearing hemodynamically stable. This is not a system review. It is the physician's assessment/observation of the patient's appearance. ROS is defined by the AMA and CMS as an inventory of body systems obtained through a series of **questions** seeking to identify signs and/or symptoms which the patient may be experiencing or has experienced. None of the PFSH are reviewed as this information is in the medical record and the physician reviewed the chart. No PFSH is required for a level 2 or an expanded problem focused PFSH. This is a level 2 or expanded problem focused history.

The examination included 4 constitutional elements: blood pressure, pulse, respiration, and temperature, which equals 1 OS. There were 8 BAs examined: head (normocephalic), neck (supple), chest (symmetrical), abdomen (soft, nontender, obese), and extremities (no gross deformities, counts as 4). There were 6 OSs examined: ophthalmologic (conjunctivae and sclerae), otolaryngologic (no nasal discharge or aural [ear] discharge, mouth, pharynx), cardiovascular (S1-4 [heart sounds], extremities reveal no edema, pulses are full and equal), respiratory (no retractions, rhonchi, crackles, or wheezes), gastrointestinal (bowel sounds), and lymphatic (lymphadenopathy) for a total of 15 BAs/OSs or a level 4 comprehensive examination, which would ordinarily make this a level 4 or comprehensive examination; however, only OSs are counted for the comprehensive level. With a total of 7 OSs, this examination is a level 3 or detailed physical examination.

The MDM contained a multiple number of diagnoses/management options (abdominal pain, severe hypertriglyceridemia, ear infection), a minimal amount of data to review (one lab test), and a low risk to the patient if untreated for a level 2 or low MDM.

The first numbered item of the Assessment/Plan section of the report indicates a diagnosis of abdominal pain (R10.9) and hypertriglyceridemia (E78.1). The pancreatitis is a "rule out" diagnosis, which physician coders do not code, and the questionable ear infection is a suspected diagnosis, which physician coders do not code. The ear pain (H92.02) is reported as it is indicated in the first paragraph of the report.

CHAPTER 1, CASE 1-6A

HISTORY ELEMENTS				Documented
<b>HISTORY OF PRESENT ILLNESS (HPI)</b>				
1. Location (site on body)				X
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)				X
8. Associated signs and symptoms (what else is happening when it occurs)				
*Duration not in CPT as HPI Element				
TOTAL				2
LEVEL				2
<b>REVIEW OF SYSTEMS (ROS)</b>				Documented
1. Constitutional (e.g., weight loss, fever)				
2. Ophthalmologic (eyes)				
3. Otolaryngologic (ears, nose, mouth, throat)				X
4. Cardiovascular				
5. Respiratory				X
6. Gastrointestinal				X
7. Genitourinary				
8. Musculoskeletal				
9. Integumentary (skin and/or breasts)				
10. Neurological				
11. Psychiatric				
12. Endocrine				
13. Hematologic/Lymphatic				
14. Allergic/Immunologic				
TOTAL				3
LEVEL				3
<b>PAST, FAMILY, AND/OR SOCIAL HISTORY (PFSH)</b>				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				
TOTAL				0
LEVEL				2
History Level	1	2	3	4
	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
HPI	Brief 1-3	Brief 1-3	Extended 4+	Extended 4+
ROS	None	Problem Pertinent 1	Extended 2-9	Complete 10+
PFSH	None	None	Pertinent 1	Complete 2-3
HISTORY LEVEL				2

EXAMINATION ELEMENTS				Documented
<b>CONSTITUTIONAL (OS)</b>				
• Blood pressure, sitting				
• Blood pressure, lying				X
• Pulse				X
• Respirations				X
• Temperature				X
• Height				
• Weight				
• General appearance				
(Counts as only 1)				1
NUMBER				1
<b>BODY AREAS (BA)</b>				Documented
1. Head (including face)				X
2. Neck				X
3. Chest (including breasts and axillae)				X
4. Abdomen				X
5. Genitalia, groin, buttocks				
6. Back (including spine)				
7. Each extremity				XXXX
NUMBER				8
<b>ORGAN SYSTEMS (OS)</b>				Documented
1. Ophthalmologic (eyes)				X
2. Otolaryngologic (ears, nose, mouth, throat)				X
3. Cardiovascular				X
4. Respiratory				X
5. Gastrointestinal				X
6. Genitourinary				
7. Musculoskeletal				
8. Integumentary (skin)				
9. Neurologic				
10. Psychiatric				
11. Hematologic/Lymphatic/Immunologic				X
NUMBER				6
TOTAL BA/OS				15(7)
Exam Level	1	2	3	4
	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
	Limited to affected BA/OS	Limited to affected BA/OS & other related OS(s)	Extended of affected BA(s) & other related OS(s)	General multi-system (OSs only)
# of OS or BA	1	2-7 limited	2-7 extended	8+
EXAMINATION LEVEL				3

MDM ELEMENTS					Documented
<b># OF DIAGNOSIS/MANAGEMENT OPTIONS</b>					
1. Minimal					
2. Limited					
3. Multiple					X
4. Extensive					
LEVEL					3
<b>AMOUNT AND/OR COMPLEXITY OF DATA TO REVIEW</b>					Documented
1. Minimal/None					X
2. Limited					
3. Moderate					
4. Extensive					
LEVEL					1
<b>RISK OF COMPLICATION OR DEATH IF NOT TREATED</b>					Documented
1. Minimal					
2. Low					X
3. Moderate					
4. High					
LEVEL					2
MDM*	1	2	3	4	
	Straightforward	Low	Moderate	High	
Number of DX or management options	Minimal	Limited	Multiple	Extensive	
Amount and/or complexity of data	Minimal/None	Limited	Moderate	Extensive	
Risks	Minimal	Low	Moderate	High	
MDM LEVEL					2
*To qualify for a given type of MDM complexity, 2 of 3 elements in the table must be met or exceeded.					

History: Expanded Problem Focused  
 Examination: Detailed  
 MDM: Low  
 Number of Key Components: 2 of 3  
 99232

## CASE 1-7

### 1-7A PROGRESS REPORT

#### CASE 1-7

##### 1-7A PROGRESS REPORT

**Professional Services:** 99232 (Evaluation and Management, Hospital)

**ICD-10-CM DX:** N17.9 (Failure, failed, renal, acute), N18.9 (Failure, failed, renal, chronic), D63.1 (Anemia, in, chronic kidney disease), I48.91 (Fibrillation, atrial or auricular [established])

**RATIONALE:** No HPI. There is no ROS (level 1). There are statements of the physician's observation/assessment of the patient's appearance related to appearing hemodynamically stable and not in respiratory distress; however, these are not considered ROS. See rationale 1-6A for further explanation. No PFSH was elicited (level 2). This history does not count as there was no HPI.

There are 3 constitutional elements of the examination including the blood pressure, pulse (heart rate), and respirations for 1 OS. There were 7 BAs examined: head (normocephalic), chest (symmetrical), extremities (arthritic changes, counts as 4), and abdomen (soft, nontender). There were 4 OSs examined: cardiovascular (S1-4 [heart sounds], pulses are fair), respiratory (positive crackles, no wheezing), gastrointestinal (bowel sounds), and ophthalmologic (conjunctiva, sclerae) for a total of 12 BAs/OSs, which would ordinarily make this a level 4 or comprehensive examination; however, only OSs are counted for the comprehensive level. With a total of 5 OSs, this examination is a level 3 or detailed physical examination.

The MDM included extensive diagnoses/management options (renal failure, status post rupture, status post tracheostomy, anemia, atrial fibrillation), minimal data to review (labs and input/output), and moderate risk if untreated and the patient's condition is improving. This is a level 3 or moderate MDM.

When both acute (N17.9) and chronic renal failure (N18.9) exist, assign a code for each and sequence the acute code first, according to the Official Guidelines for Coding and Reporting. The stage of kidney failure is not stated, so N18.9 is reported for unspecified chronic kidney disease. The status post tracheostomy is not coded as it has no effect on the treatment of the current condition. Questionable small bowel obstruction is not coded as it is only suspected.

CHAPTER 1, CASE 1-7A

HISTORY ELEMENTS				Documented
<b>HISTORY OF PRESENT ILLNESS (HPI)</b>				
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	TOTAL		0	
	LEVEL		0	
<b>REVIEW OF SYSTEMS (ROS)</b>				
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				
14. Allergic/Immunologic				
	TOTAL		0	
	LEVEL		1	
<b>PAST, FAMILY, AND/OR SOCIAL HISTORY (PFSH)</b>				
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		0	
	LEVEL		2	
History Level	1	2	3	4
	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
HPI	Brief 1-3	Brief 1-3	Extended 4+	Extended 4+
ROS	None	Problem Pertinent 1	Extended 2-9	Complete 10+
PFSH	None	None	Pertinent 1	Complete 2-3
	HISTORY LEVEL			0

EXAMINATION ELEMENTS				Documented
<b>CONSTITUTIONAL (OS)</b>				
• Blood pressure, sitting				
• Blood pressure, lying				X
• Pulse				X
• Respirations				X
• Temperature				
• Height				
• Weight				
• General appearance				
	(Counts as only 1)	NUMBER		1
<b>BODY AREAS (BA)</b>				
1. Head (including face)				X
2. Neck				
3. Chest (including breasts and axillae)				X
4. Abdomen				X
5. Genitalia, groin, buttocks				
6. Back (including spine)				
7. Each extremity				XXXX
		NUMBER		7
<b>ORGAN SYSTEMS (OS)</b>				
1. Ophthalmologic (eyes)				X
2. Otolaryngologic (ears, nose, mouth, throat)				
3. Cardiovascular				X
4. Respiratory				X
5. Gastrointestinal				X
6. Genitourinary				
7. Musculoskeletal				
8. Integumentary (skin)				
9. Neurologic				
10. Psychiatric				
11. Hematologic/Lymphatic/Immunologic				
		NUMBER		4
		TOTAL BA/OS		12(5)
Exam Level	1	2	3	4
	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
	Limited to affected BA/OS	Limited to affected BA/OS & other related OS(s)	Extended of affected BA(s) & other related OS(s)	General multi-system (OSs only)
# of OS or BA	1	2-7 limited	2-7 extended	8+
	EXAMINATION LEVEL			3

MDM ELEMENTS				Documented
# OF DIAGNOSIS/MANAGEMENT OPTIONS				
1. Minimal				
2. Limited				
3. Multiple				
4. Extensive				X
LEVEL				4
AMOUNT AND/OR COMPLEXITY OF DATA TO REVIEW				Documented
1. Minimal/None				X
2. Limited				
3. Moderate				
4. Extensive				
LEVEL				I
RISK OF COMPLICATION OR DEATH IF NOT TREATED				Documented
1. Minimal				
2. Low				
3. Moderate				X
4. High				
LEVEL				3
MDM*	I	2	3	4
	Straightforward	Low	Moderate	High
Number of DX or management options	Minimal	Limited	Multiple	Extensive
Amount and/or complexity of data	Minimal/None	Limited	Moderate	Extensive
Risks	Minimal	Low	Moderate	High
MDM LEVEL				3
*To qualify for a given type of MDM complexity, 2 of 3 elements in the table must be met or exceeded.				

History: None  
 Examination: Detailed  
 MDM: Moderate  
 Number of Key Components: 2 of 3  
 99232

## CASE 1-8

### 1-8A PROGRESS REPORT

#### CASE 1-8

##### 1-8A PROGRESS REPORT

**Professional Services:** 99232 (Evaluation and Management, Hospital)

**ICD-10-CM DX:** R10.9 (Pain[s], abdominal), E78.1 (Hypertriglyceridemia, essential), E03.9 (Hypothyroidism), I10 (Hypertension)

**RATIONALE:** No HPI. The patient medical record was reviewed by the physician and statements made regarding the status of the patient. The ROS included one system: gastrointestinal (no abdominal discomfort/dyspepsia). As in cases 1-6A and 1-7A, there are statements of the patient's appearance as it relates to hemodynamic and respiratory status, but these are the physician's assessment/observation, not ROS. There was no PFSH. No level was assigned to this because there was no HPI.

The examination included 4 constitutional elements: blood pressure, pulse (heart rate), respiration, and temperature for 1 OS. There were 8 BAs included in the examination: chest (symmetrical), head (normocephalic), neck (supple), abdomen (soft, nontender), and extremities (no gross deformities, counts as 4). There were 6 OSs examined: ophthalmologic (conjunctivae, sclerae), otolaryngologic (no nasal, aural discharge, tongue, pharynx), cardiovascular (JVD, S1-4 [heart sounds], edema, pulses are full and equal), gastrointestinal (positive bowel sounds), respiratory (no rhonchi, crackles, or wheezes), and lymphatic (lymphadenopathy) for a total of 15 BAs/OSs, which would ordinarily make this a level 4 or comprehensive examination; however, only OSs are counted for the comprehensive level. With a total of 7 OSs, this examination is a level 3 or detailed physical examination.

The MDM required multiple diagnoses/management options (abdominal pain, hypertriglyceridemia, hypothyroid, fairly controlled hypertension), minimal data to review (labs only), and moderate risks or a level 3 moderate MDM.

Diagnoses are as stated in the Assessment/Plan section of the report as abdominal pain (R10.9), hypertriglyceridemia (E78.1), hypothyroidism (E03.9), and hypertension (I10).

CHAPTER 1, CASE 1-8A

HISTORY ELEMENTS				Documented
<b>HISTORY OF PRESENT ILLNESS (HPI)</b>				
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	TOTAL		0	
	LEVEL		0	
<b>REVIEW OF SYSTEMS (ROS)</b>				
1. Constitutional (e.g., weight loss, fever)				
2. Ophthalmologic (eyes)				
3. Otolaryngologic (ears, nose, mouth, throat)				
4. Cardiovascular				
5. Respiratory				
6. Gastrointestinal			X	
7. Genitourinary				
8. Musculoskeletal				
9. Integumentary (skin and/or breasts)				
10. Neurological				
11. Psychiatric				
12. Endocrine				
13. Hematologic/Lymphatic				
14. Allergic/Immunologic				
	TOTAL		1	
	LEVEL		2	
<b>PAST, FAMILY, AND/OR SOCIAL HISTORY (PFSH)</b>				
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		0	
	LEVEL		2	
History Level	1	2	3	4
	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
HPI	Brief 1-3	Brief 1-3	Extended 4+	Extended 4+
ROS	None	Problem Pertinent 1	Extended 2-9	Complete 10+
PFSH	None	None	Pertinent 1	Complete 2-3
	HISTORY LEVEL			0

EXAMINATION ELEMENTS				Documented
<b>CONSTITUTIONAL (OS)</b>				
• Blood pressure, sitting				
• Blood pressure, lying				X
• Pulse				X
• Respirations				X
• Temperature				X
• Height				
• Weight				
• General appearance				
	(Counts as only 1)	NUMBER		1
<b>BODY AREAS (BA)</b>				
1. Head (including face)				X
2. Neck				X
3. Chest (including breasts and axillae)				X
4. Abdomen				X
5. Genitalia, groin, buttocks				
6. Back (including spine)				
7. Each extremity				XXXX
		NUMBER		8
<b>ORGAN SYSTEMS (OS)</b>				
1. Ophthalmologic (eyes)				X
2. Otolaryngologic (ears, nose, mouth, throat)				X
3. Cardiovascular				X
4. Respiratory				X
5. Gastrointestinal				X
6. Genitourinary				
7. Musculoskeletal				
8. Integumentary (skin)				
9. Neurologic				
10. Psychiatric				
11. Hematologic/Lymphatic/Immunologic				X
		NUMBER		6
		TOTAL BA/OS		15(7)
Exam Level	1	2	3	4
	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
	Limited to affected BA/OS	Limited to affected BA/OS & other related OS(s)	Extended of affected BA(s) & other related OS(s)	General multi-system (OSs only)
# of OS or BA	1	2-7 limited	2-7 extended	8+
	EXAMINATION LEVEL			3

MDM ELEMENTS				Documented
# OF DIAGNOSIS/MANAGEMENT OPTIONS				
1. Minimal				
2. Limited				
3. Multiple				X
4. Extensive				
LEVEL				3
AMOUNT AND/OR COMPLEXITY OF DATA TO REVIEW				Documented
1. Minimal/None				X
2. Limited				
3. Moderate				
4. Extensive				
LEVEL				1
RISK OF COMPLICATION OR DEATH IF NOT TREATED				Documented
1. Minimal				
2. Low				
3. Moderate				X
4. High				
LEVEL				3
MDM*	1	2	3	4
	Straightforward	Low	Moderate	High
Number of DX or management options	Minimal	Limited	Multiple	Extensive
Amount and/or complexity of data	Minimal/None	Limited	Moderate	Extensive
Risks	Minimal	Low	Moderate	High
MDM LEVEL				3
*To qualify for a given type of MDM complexity, 2 of 3 elements in the table must be met or exceeded.				

History: None  
 Examination: Detailed  
 MDM: Moderate  
 Number of Key Components: 2 of 3  
 99232



## CASE 1-9

### 1-9A DISCHARGE SUMMARY

#### CASE 1-9

##### 1-9A DISCHARGE SUMMARY

**Professional Services: 99238** (Evaluation and Management, Hospital, Discharge)

**ICD-10-CM DX: K26.7** (Ulcer, duodenum/duodenal, chronic)

**RATIONALE:** There is no audit form with this case because the hospital discharge services are based on the time the physician spends in the final discharge of the patient. The service may or may not include an examination of the patient. Since the physician did not indicate the time spent on discharge of the patient, the lowest level of discharge is reported with 99238.

The diagnosis is as stated on the Discharge Diagnosis as nonhealing chronic duodenal ulcer (K26.7).

## CASE 1-10

### 1-10A CONSULTATION

#### CASE 1-10

##### 1-10A CONSULTATION

**Professional Services: 99242** (Evaluation and Management, Consultation)

**ICD-10-CM DX: I83.812** (Varix, leg, left, with, pain)

**RATIONALE:** There were 5 elements included in the HPI: location (thigh), severity (rather severe), context (developed after pregnancy on her feet for long periods of time), modifying factors (support stockings), and timing (standing) for a level 4 or comprehensive HPI. There are 2 elements in the ROS: cardiovascular (no previous DVT) and genitourinary (hysterectomy) for a detailed or level 3 ROS. Two elements of the PFSH were reviewed (past history of hysterectomy, medications were reviewed) and a social history (works in a nursing home) for a level 4 or comprehensive PFSH. The history contains 4 HPI, 2 ROS, and 2 PFSH which make the history detailed.

Some would not count the hysterectomy as an element of the ROS, which would reduce the history to a level 2 or expanded problem focused history. This, however, would not change the code assignment since the examination level is at a level 2 or expanded problem focused level. Since this category of codes requires all 3 of the key components to be at the level specified in the code, the increased level on the history would not affect code assignment.

The examination contained 2 BAs (both extremities) for an expanded problem focused or level 2 service.

The MDM included multiple diagnoses/management options (new problem to this physician), no data to be reviewed, and a moderate risk to patient if untreated (one chronic problem with mild exacerbation). This is a moderate MDM.

The diagnosis is varicose veins (I83.812) as stated in the first paragraph of the report as "painful varicose veins."

## CHAPTER 1, CASE 1-10A

HISTORY ELEMENTS		Documented		
HISTORY OF PRESENT ILLNESS (HPI)				
1. Location (site on body)		X		
2. Quality (characteristic: throbbing, sharp)				
3. Severity (1/10 or how intense)		X		
4. Duration* (how long for problem or episode)				
5. Timing (when it occurs)		X		
6. Context (under what circumstances does it occur)		X		
7. Modifying factors (what makes it better or worse)		X		
8. Associated signs and symptoms (what else is happening when it occurs)				
*Duration not in CPT as HPI Element	TOTAL	5		
	LEVEL	4		
REVIEW OF SYSTEMS (ROS)				
Documented				
1. Constitutional (e.g., weight loss, fever)				
2. Ophthalmologic (eyes)				
3. Otolaryngologic (ears, nose, mouth, throat)				
4. Cardiovascular		X		
5. Respiratory				
6. Gastrointestinal				
7. Genitourinary		X		
8. Musculoskeletal				
9. Integumentary (skin and/or breasts)				
10. Neurological				
11. Psychiatric				
12. Endocrine				
13. Hematologic/Lymphatic				
14. Allergic/Immunologic				
	TOTAL	2		
	LEVEL	3		
PAST, FAMILY, AND/OR SOCIAL HISTORY (PFSH)				
Documented				
1. Past illness, operations, injuries, treatments, and current medications		X		
2. Family medical history for heredity and risk				
3. Social activities, both past and present		X		
	TOTAL	2		
	LEVEL	4		
History Level	1	2	3	4
	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
HPI	Brief 1-3	Brief 1-3	Extended 4+	Extended 4+
ROS	None	Problem Pertinent 1	Extended 2-9	Complete 10+
PFSH	None	None	Pertinent 1	Complete 2-3
HISTORY LEVEL				3

EXAMINATION ELEMENTS		Documented		
CONSTITUTIONAL (OS)				
• Blood pressure, sitting				
• Blood pressure, lying				
• Pulse				
• Respirations				
• Temperature				
• Height				
• Weight				
• General appearance				
(Counts as only 1) NUMBER		0		
BODY AREAS (BA)				
		Documented		
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		XX		
NUMBER		2		
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				
NUMBER		0		
TOTAL BA/OS		2		
Exam Level	1	2	3	4
	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
	Limited to affected BA/OS	Limited to affected BA/OS & other related OS(s)	Extended of affected BA(s) & other related OS(s)	General multi-system (OSs only)
# of OS or BA	1	2-7 limited	2-7 extended	8+
EXAMINATION LEVEL				2

MDM ELEMENTS		Documented		
# OF DIAGNOSIS/MANAGEMENT OPTIONS				
1. Minimal				
2. Limited				
3. Multiple		X		
4. Extensive				
	LEVEL	3		
AMOUNT AND/OR COMPLEXITY OF DATA TO REVIEW		Documented		
1. Minimal/None		X		
2. Limited				
3. Moderate				
4. Extensive				
	LEVEL	I		
RISK OF COMPLICATION OR DEATH IF NOT TREATED		Documented		
1. Minimal				
2. Low				
3. Moderate		X		
4. High				
	LEVEL	3		
MDM*	I	2	3	4
	Straightforward	Low	Moderate	High
Number of DX or management options	Minimal	Limited	Multiple	Extensive
Amount and/or complexity of data	Minimal/None	Limited	Moderate	Extensive
Risks	Minimal	Low	Moderate	High
MDM LEVEL				3
*To qualify for a given type of MDM complexity, 2 of 3 elements in the table must be met or exceeded.				

History: Detailed  
Examination: Expanded Problem Focused  
MDM: Moderate

Number of Key Components: 3 of 3

99242

**CASE 1-11**  
**1-11A CONSULTATION**
**CASE 1-11**
**1-11A CONSULTATION**

**Professional Services: 99245** (Evaluation and Management, Consultation)

**ICD-10-CM DX: K27.7** (Ulcer, peptic, chronic), **F17.210** (Dependence, drug, nicotine, cigarettes)

**RATIONALE:** There are 5 HPI elements: severity (now in need of surgery), modifying factors (Zantac and Prilosec), quality (benign), timing (recurrent), and associated signs and symptoms (elevated CEA—carcino-embryonic antigen, negative for lymphadenopathy) for a level 4 or comprehensive HPI. There are 2 elements in the ROS: gastrointestinal and hematology for a level 3 or a detailed ROS. All 3 of the PFSH elements were included for a comprehensive PFSH (level 4). This is a level 3 or detailed history.

There was one constitutional element: general appearance (no acute distress), which equals 1 OS. There are 7 BAs: neck, chest (barrel-shaped), abdomen (soft, nontender), and extremities (no clubbing, counts as 4). There were 7 OSs examined: ophthalmologic, otolaryngologic (ENT), cardiovascular (cardiac; aorta; extremities, no edema; cyanosis), respiratory (without dullness to percussion, rhonchi), neurologic, gastrointestinal (liver), and lymphatic (no lymphadenopathy). There were a total of 15 BAs/OSs examined, which would ordinarily make this a level 4 or comprehensive examination; however, only OSs are counted for the comprehensive level. When recounting, not including BAs, there are 7 OSs and 1 OS for the constitutional, which still equals a level 4 or comprehensive level examination.

The MDM included an extensive number of diagnoses/management options, a limited amount/complexity of data, and a high risk to the patient. This is a high MDM (level 4).

This case has a detailed history, comprehensive examination, and high MDM. Since all 3 of the key components must be met before you can assign a code in the consultation area, this case would have been a 99243, but with the last statement of “a total of 80 minutes...,” it is possible to bill on the time spent, moving this service to the 99245 level because he documented the time and proved that greater than 50% of the total time was spent in counseling or coordination of care. The case would have to move to the highest level in the category and exceed the time stated in the description of that highest code before you could consider assigning a prolonged service code.

The diagnosis is as stated in the Impression/Plan section of the report as peptic ulcer (K27.7). The tobacco dependency (F17.210) is reported due to smoking advice given during the visit.

## CHAPTER 1, CASE 1-11A

HISTORY ELEMENTS				Documented
<b>HISTORY OF PRESENT ILLNESS (HPI)</b>				
1. Location (site on body)				
2. Quality (characteristic: throbbing, sharp)				X
3. Severity (1/10 or how intense)				X
4. Duration* (how long for problem or episode)				
5. Timing (when it occurs)				X
6. Context (under what circumstances does it occur)				
7. Modifying factors (what makes it better or worse)				X
8. Associated signs and symptoms (what else is happening when it occurs)				X
*Duration not in CPT as HPI Element	TOTAL			5
	LEVEL			4
<b>REVIEW OF SYSTEMS (ROS)</b>				
1. Constitutional (e.g., weight loss, fever)				
2. Ophthalmologic (eyes)				
3. Otolaryngologic (ears, nose, mouth, throat)				
4. Cardiovascular				
5. Respiratory				
6. Gastrointestinal				X
7. Genitourinary				
8. Musculoskeletal				
9. Integumentary (skin and/or breasts)				
10. Neurological				
11. Psychiatric				
12. Endocrine				
13. Hematologic/Lymphatic				X
14. Allergic/Immunologic				
	TOTAL			2
	LEVEL			3
<b>PAST, FAMILY, AND/OR SOCIAL HISTORY (PFSH)</b>				
1. Past illness, operations, injuries, treatments, and current medications				X
2. Family medical history for heredity and risk				X
3. Social activities, both past and present				X
	TOTAL			3
	LEVEL			4
History Level	1	2	3	4
	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
HPI	Brief 1-3	Brief 1-3	Extended 4+	Extended 4+
ROS	None	Problem Pertinent 1	Extended 2-9	Complete 10+
PFSH	None	None	Pertinent 1	Complete 2-3
	HISTORY LEVEL			3

EXAMINATION ELEMENTS				Documented
<b>CONSTITUTIONAL (OS)</b>				
• Blood pressure, sitting				
• Blood pressure, lying				
• Pulse				
• Respirations				
• Temperature				
• Height				
• Weight				
• General appearance				X
	(Counts as only 1)	NUMBER		1
<b>BODY AREAS (BA)</b>				
1. Head (including face)				
2. Neck				X
3. Chest (including breasts and axillae)				X
4. Abdomen				X
5. Genitalia, groin, buttocks				
6. Back (including spine)				
7. Each extremity				XXXX
		NUMBER		7
<b>ORGAN SYSTEMS (OS)</b>				
1. Ophthalmologic (eyes)				X
2. Otolaryngologic (ears, nose, mouth, throat)				X
3. Cardiovascular				X
4. Respiratory				X
5. Gastrointestinal				X
6. Genitourinary				
7. Musculoskeletal				
8. Integumentary (skin)				
9. Neurologic				X
10. Psychiatric				
11. Hematologic/Lymphatic/Immunologic				X
		NUMBER		7
		TOTAL BA/OS		15(8)
Exam Level	1	2	3	4
	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
	Limited to affected BA/OS	Limited to affected BA/OS & other related OS(s)	Extended of affected BA(s) & other related OS(s)	General multi-system (OSs only)
# of OS or BA	1	2-7 limited	2-7 extended	8+
	EXAMINATION LEVEL			4

MDM ELEMENTS				Documented
# OF DIAGNOSIS/MANAGEMENT OPTIONS				
1. Minimal				
2. Limited				
3. Multiple				
4. Extensive				X
LEVEL				4
AMOUNT AND/OR COMPLEXITY OF DATA TO REVIEW				
1. Minimal/None				
2. Limited				X
3. Moderate				
4. Extensive				
LEVEL				2
RISK OF COMPLICATION OR DEATH IF NOT TREATED				
1. Minimal				
2. Low				
3. Moderate				
4. High				X
LEVEL				4
MDM*	1	2	3	4
	Straightforward	Low	Moderate	High
Number of DX or management options	Minimal	Limited	Multiple	Extensive
Amount and/or complexity of data	Minimal/None	Limited	Moderate	Extensive
Risks	Minimal	Low	Moderate	High
MDM LEVEL				4
*To qualify for a given type of MDM complexity, 2 of 3 elements in the table must be met or exceeded.				

History: Detailed  
Examination: Comprehensive  
MDM: High

Number of Key Components: 3 of 3

99245

**CASE 1-12**  
**1-12A CONSULTATION**  
**1-12B PROGRESS REPORT**  
**1-12C PROGRESS REPORT**

**CASE 1-12**

1-12A CONSULTATION

**Professional Services: 99253** (Evaluation and Management, Consultation)

**ICD-10-CM DX: N17.9** (Failure/failed, renal, acute)

**RATIONALE:** There were 5 HPI elements included: location (kidney stone), severity (severe dehydration), context (presumed CVA, see paragraph 5), associated signs and symptoms (laboratory results in paragraph 4), and modifying factors (gentamicin, steroids) for a level 4 or a comprehensive HPI. All 14 elements were reviewed in the ROS for a level 4 or comprehensive ROS. All 3 of the PFSH elements were reviewed for a level 4, making the history a level 4 or comprehensive.

The examination included 3 constitutional elements or 1 OS, blood pressure, pulse (heart rate), and respiration. There were 7 BAs: neck (supple), chest (symmetrical expansions), extremities (counts as 4), and abdomen (obese). There were 6 organ systems: ophthalmologic (conjunctivae, sclerae, and extraocular muscles), otolaryngologic (pharynx, tongue, and buccal mucosa), cardiovascular (S1-4 [heart sounds], pulses are fair), respiratory (poor inspiration, lung fields), gastrointestinal (bowel sound), and lymphatic (no lymphadenopathy) for 14 BAs/OSs or a level 4 or comprehensive examination, which would ordinarily make this a level 4 or comprehensive level examination; however, only OSs are counted for the comprehensive level. With a total of 7 OSs, this examination is a level 3 or detailed physical examination.

The MDM contained an extensive number of diagnoses/management options (acute renal failure, volume depletion, acute interstitial nephritis), an extensive amount of data (reviewed lab data, ultrasound, and past medical records, input/output), and a high degree of risk (illness that presents a threat to life or bodily function), making this a level 4 or high level of MDM complexity.

The diagnosis is in the Assessment/Plan section of the report as acute renal failure (N17.9). The intravascular volume depletion, nephrotoxic ATN (acute tubular necrosis), and the acute interstitial nephritis are not reported because the physician stated the acute renal failure was secondary to each of these conditions. Also, the report states “either/or” diagnoses with the statement “either nephrotoxic ATN or acute interstitial nephritis.” Outpatient/Physician coders do not report “either/or” diagnoses. **Note:** Payment for a consultation is subject to Medicare guidelines.

CHAPTER 1, CASE 1-12A

HISTORY ELEMENTS				Documented
<b>HISTORY OF PRESENT ILLNESS (HPI)</b>				
1. Location (site on body)				X
2. Quality (characteristic: throbbing, sharp)				X
3. Severity (1/10 or how intense)				X
4. Duration* (how long for problem or episode)				
5. Timing (when it occurs)				
6. Context (under what circumstances does it occur)				X
7. Modifying factors (what makes it better or worse)				X
8. Associated signs and symptoms (what else is happening when it occurs)				X
*Duration not in CPT as HPI Element	TOTAL			5
	LEVEL			4
<b>REVIEW OF SYSTEMS (ROS)</b>				
1. Constitutional (e.g., weight loss, fever)				X
2. Ophthalmologic (eyes)				X
3. Otolaryngologic (ears, nose, mouth, throat)				X
4. Cardiovascular				X
5. Respiratory				X
6. Gastrointestinal				X
7. Genitourinary				X
8. Musculoskeletal				X
9. Integumentary (skin and/or breasts)				X
10. Neurological				X
11. Psychiatric				X
12. Endocrine				X
13. Hematologic/Lymphatic				X
14. Allergic/Immunologic				X
	TOTAL			14
	LEVEL			4
<b>PAST, FAMILY, AND/OR SOCIAL HISTORY (PFSH)</b>				
1. Past illness, operations, injuries, treatments, and current medications				X
2. Family medical history for heredity and risk				X
3. Social activities, both past and present				X
	TOTAL			3
	LEVEL			4
History Level	1	2	3	4
	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
HPI	Brief 1-3	Brief 1-3	Extended 4+	Extended 4+
ROS	None	Problem Pertinent 1	Extended 2-9	Complete 10+
PFSH	None	None	Pertinent 1	Complete 2-3
	HISTORY LEVEL			4

EXAMINATION ELEMENTS				Documented
<b>CONSTITUTIONAL (OS)</b>				
• Blood pressure, sitting				
• Blood pressure, lying				X
• Pulse				X
• Respirations				X
• Temperature				
• Height				
• Weight				
• General appearance				
	(Counts as only 1)	NUMBER		1
<b>BODY AREAS (BA)</b>				
1. Head (including face)				X
2. Neck				X
3. Chest (including breasts and axillae)				X
4. Abdomen				X
5. Genitalia, groin, buttocks				
6. Back (including spine)				
7. Each extremity				XXXX
		NUMBER		7
<b>ORGAN SYSTEMS (OS)</b>				
1. Ophthalmologic (eyes)				X
2. Otolaryngologic (ears, nose, mouth, throat)				X
3. Cardiovascular				X
4. Respiratory				X
5. Gastrointestinal				X
6. Genitourinary				
7. Musculoskeletal				
8. Integumentary (skin)				
9. Neurologic				
10. Psychiatric				
11. Hematologic/Lymphatic/Immunologic				X
		NUMBER		6
		TOTAL BA/OS		14(7)
Exam Level	1	2	3	4
	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
	Limited to affected BA/OS	Limited to affected BA/OS & other related OS(s)	Extended of affected BA(s) & other related OS(s)	General multi-system (OSs only)
# of OS or BA	1	2-7 limited	2-7 extended	8+
	EXAMINATION LEVEL			3

MDM ELEMENTS				Documented
# OF DIAGNOSIS/MANAGEMENT OPTIONS				
1. Minimal				
2. Limited				
3. Multiple				
4. Extensive				X
LEVEL				4
AMOUNT AND/OR COMPLEXITY OF DATA TO REVIEW				
1. Minimal/None				Documented
2. Limited				
3. Moderate				
4. Extensive				X
LEVEL				4
RISK OF COMPLICATION OR DEATH IF NOT TREATED				
1. Minimal				
2. Low				
3. Moderate				
4. High				X
LEVEL				4
MDM*	1	2	3	4
	Straightforward	Low	Moderate	High
Number of DX or management options	Minimal	Limited	Multiple	Extensive
Amount and/or complexity of data	Minimal/None	Limited	Moderate	Extensive
Risks	Minimal	Low	Moderate	High
MDM LEVEL				4
*To qualify for a given type of MDM complexity, 2 of 3 elements in the table must be met or exceeded.				

History: Comprehensive  
Examination: Detailed  
MDM: High

Number of Key Components: 3 of 3

99253

## 1-12B PROGRESS REPORT

**Professional Services: 99233** (Evaluation and Management, Hospital), **99356** (Evaluation and Management, Prolonged Services)

**ICD-10-CM DX: T36.5X5A** (Table of Drugs and Chemicals, Gentamicin, External Cause [T-code], Adverse Effect), **N17.9** (Failure, failed, renal, acute)

**RATIONALE:** *There is a brief history in that the physician states that the patient has been on steroids for 5-7 days and requires hemodialysis.*

*There were 4 constitutional elements examined: blood pressure, pulse (heart rate), respiration, and temperature, which equals 1 OS. There were 7 BAs examined: neck, chest, extremities (counts as 4), and abdomen (soft, nontender). There were 7 OSs examined: ophthalmologic (conjunctivae, sclerae), otolaryngologic (no nasal or aural discharge, tongue, buccal mucosa), cardiovascular (S1-4 [heart sounds], pulses are fair), respiratory (breath sounds, rhonchi, crackles, wheezes), gastrointestinal (bowel sounds), musculoskeletal (arthritic changes in extremities), and lymphatic (lymphadenopathy) for a total of 15 BAs/OSs, which would ordinarily make this a level 4 or comprehensive examination; however, only OSs are counted for the comprehensive level. When recounting without the BAs, there was 1 constitutional (which counts as 1 OS) and 7 OSs for a total of 8 OSs, which is a level 4 or comprehensive examination.*

*The MDM included an extensive number of diagnoses/management options, minimal amount of data to review (lab results), and a high level of risk if left untreated (renal failure). Her condition is worsening, requires more aggressive treatment, and the physician is considering recommending DNR to the family. This makes this a high level. This is a level 4 or high MDM.*

*The key components support the high level 99233. If the key components had not supported the 99233, the coder would still assign the 99233 based on time because the service was dominated by counseling. The statement by the physician in the medical record that the total time was 85 minutes and over 50% of the time was spent on counseling supports the highest level (99233). The typical time for 99233 is 35 minutes. This service was 85 minutes in length. The service was prolonged by 50 minutes and is also reported with 99356.*

*The diagnosis is acute renal failure as stated in the Assessment/Plan section of the report, which was caused by intravascular volume depletion (dehydration), and nephrotoxic ATN (acute tubular necrosis), secondary to a complication of gentamicin given correctly.*

*ICD-10-CM Official Guidelines for Coding and Reporting, Section 1.C.19.5.a. state to assign the appropriate code for the adverse effect. Use additional codes for the manifestations of adverse effects. The first-listed code is T36.5X5A followed by acute renal failure (N17.9).*

*The patient also has interstitial nephritis (N12); however the cause is still questionable; therefore, it cannot be related to cephalosporins as yet. The volume depletion and acute interstitial nephritis are not reported because the physician stated the acute renal failure was secondary to each of these conditions.*



CHAPTER 1, CASE 1-12B

HISTORY ELEMENTS				Documented
<b>HISTORY OF PRESENT ILLNESS (HPI)</b>				
1. Location (site on body)				X
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	TOTAL			I
	LEVEL			I
<b>REVIEW OF SYSTEMS (ROS)</b>				
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				
14. Allergic/Immunologic				
	TOTAL			0
	LEVEL			0
<b>PAST, FAMILY, AND/OR SOCIAL HISTORY (PFSH)</b>				
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			0
	LEVEL			2
History Level	1	2	3	4
	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
HPI	Brief 1-3	Brief 1-3	Extended 4+	Extended 4+
ROS	None	Problem Pertinent I	Extended 2-9	Complete 10+
PFSH	None	None	Pertinent I	Complete 2-3
	HISTORY LEVEL			I

EXAMINATION ELEMENTS				Documented
<b>CONSTITUTIONAL (OS)</b>				
• Blood pressure, sitting				
• Blood pressure, lying				X
• Pulse				X
• Respirations				X
• Temperature				X
• Height				
• Weight				
• General appearance				
	(Counts as only 1)	NUMBER		I
<b>BODY AREAS (BA)</b>				
1. Head (including face)				
2. Neck				X
3. Chest (including breasts and axillae)				X
4. Abdomen				X
5. Genitalia, groin, buttocks				
6. Back (including spine)				
7. Each extremity				XXXX
		NUMBER		7
<b>ORGAN SYSTEMS (OS)</b>				
1. Ophthalmologic (eyes)				X
2. Otolaryngologic (ears, nose, mouth, throat)				X
3. Cardiovascular				X
4. Respiratory				X
5. Gastrointestinal				X
6. Genitourinary				
7. Musculoskeletal				X
8. Integumentary (skin)				
9. Neurologic				
10. Psychiatric				
11. Hematologic/Lymphatic/Immunologic				X
		NUMBER		7
		TOTAL BA/OS		15(8)
Exam Level	1	2	3	4
	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
	Limited to affected BA/OS	Limited to affected BA/OS & other related OS(s)	Extended of affected BA(s) & other related OS(s)	General multi-system (OSs only)
# of OS or BA	1	2-7 limited	2-7 extended	8+
	EXAMINATION LEVEL			4

MDM ELEMENTS				Documented
# OF DIAGNOSIS/MANAGEMENT OPTIONS				
1. Minimal				
2. Limited				
3. Multiple				
4. Extensive				X
LEVEL				4
AMOUNT AND/OR COMPLEXITY OF DATA TO REVIEW				Documented
1. Minimal/None				X
2. Limited				
3. Moderate				
4. Extensive				
LEVEL				I
RISK OF COMPLICATION OR DEATH IF NOT TREATED				Documented
1. Minimal				
2. Low				
3. Moderate				
4. High				X
LEVEL				4
MDM*	1	2	3	4
	Straightforward	Low	Moderate	High
Number of DX or management options	Minimal	Limited	Multiple	Extensive
Amount and/or complexity of data	Minimal/None	Limited	Moderate	Extensive
Risks	Minimal	Low	Moderate	High
MDM LEVEL				4
*To qualify for a given type of MDM complexity, 2 of 3 elements in the table must be met or exceeded.				

History: Problem Focused  
Examination: Comprehensive  
MDM: High  
  
Number of Key Components: 2 of 3 (plus prolonged service)  
99233+99356

1-12C PROGRESS REPORT

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**Professional Services: 99233** (Evaluation and Management, Hospital)

**ICD-10-CM DX: T36.5X5A** (Table of Drugs and Chemicals, Gentamicin, External Cause [T-code], Adverse Effect), **N17.9** (Failure, failed, renal, acute)

**RATIONALE:** *The internal history is the patient's decision not to have aggressive therapy by means of dialysis or kidney transplant. This is the physician's final progress note on this patient, and the review was focused on the main problem, renal failure. There are no other history elements.*

*The exam consisted of 3 constitutional elements: blood pressure, pulse (heart rate), and respirations for 1 OS. There were 8 BAs examined: head (normocephalic, atraumatic), chest, neck, extremities (arthritic changes, counts as 4), and abdomen (soft, nontender). There were 7 OSs: ophthalmologic (E in HEENT), otolaryngologic (ENT in HEENT, tongue), cardiovascular (S1-4 [heart rate], pulses), respiratory (breath sounds, rhonchi, crackles, wheezes), gastrointestinal (bowel sounds), musculoskeletal (arthritis), and lymphatic (lymphadenopathy) for a total of 16 BAs/OSs, which would ordinarily make this a level 4 or comprehensive examination; however, only OSs are counted for the comprehensive level. When recounting without the BAs, there was 1 constitutional (which counts as 1 OS) and 7 OSs for a total of 8 OSs, which is a level 4 or comprehensive examination.*

*The MDM included an extensive number of management options, minimal amount of data to review, and a high level of risk at this time if left untreated (do not resuscitate order). This is a level 4 or high MDM.*

*The diagnosis is as stated in the Assessment/Plan as acute renal failure, and caused by gentamicin and volume depletion. See explanation in rationale for 1-12B.*

CHAPTER 1, CASE 1-12C

HISTORY ELEMENTS				Documented
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	TOTAL		0	
	LEVEL		0	
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			X	
7. Genitourinary				
8. Musculoskeletal				
9. Integumentary (skin and/or breasts)				
10. Neurological				
11. Psychiatric				
12. Endocrine				
13. Hematologic/Lymphatic				
14. Allergic/Immunologic				
	TOTAL		1	
	LEVEL		1	
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				
	TOTAL		0	
	LEVEL		0	
History Level	1	2	3	4
	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
HPI	Brief 1-3	Brief 1-3	Extended 4+	Extended 4+
ROS	None	Problem Pertinent 1	Extended 2-9	Complete 10+
PFSH	None	None	Pertinent 1	Complete 2-3
	HISTORY LEVEL			0

EXAMINATION ELEMENTS				Documented
CONSTITUTIONAL (OS)				
• Blood pressure, sitting				
• Blood pressure, lying				X
• Pulse				X
• Respirations				X
• Temperature				
• Height				
• Weight				
• General appearance				
	(Counts as only 1)	NUMBER		1
BODY AREAS (BA)				
1. Head (including face)				X
2. Neck				X
3. Chest (including breasts and axillae)				X
4. Abdomen				X
5. Genitalia, groin, buttocks				
6. Back (including spine)				
7. Each extremity				XXXX
		NUMBER		8
ORGAN SYSTEMS (OS)				
1. Ophthalmologic (eyes)				X
2. Otolaryngologic (ears, nose, mouth, throat)				X
3. Cardiovascular				X
4. Respiratory				X
5. Gastrointestinal				X
6. Genitourinary				
7. Musculoskeletal				X
8. Integumentary (skin)				
9. Neurologic				
10. Psychiatric				
11. Hematologic/Lymphatic/Immunologic				X
		NUMBER		7
		TOTAL BA/OS		16(8)
Exam Level	1	2	3	4
	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
	Limited to affected BA/OS	Limited to affected BA/OS & other related OS(s)	Extended of affected BA(s) & other related OS(s)	General multi-system (OSs only)
# of OS or BA	1	2-7 limited	2-7 extended	8+
	EXAMINATION LEVEL			4

MDM ELEMENTS				Documented
# OF DIAGNOSIS/MANAGEMENT OPTIONS				
1. Minimal				
2. Limited				
3. Multiple				
4. Extensive				X
LEVEL				4
AMOUNT AND/OR COMPLEXITY OF DATA TO REVIEW				Documented
1. Minimal/None				X
2. Limited				
3. Moderate				
4. Extensive				
LEVEL				I
RISK OF COMPLICATION OR DEATH IF NOT TREATED				Documented
1. Minimal				
2. Low				
3. Moderate				
4. High				X
LEVEL				4
MDM*	I	2	3	4
	Straightforward	Low	Moderate	High
Number of DX or management options	Minimal	Limited	Multiple	Extensive
Amount and/or complexity of data	Minimal/None	Limited	Moderate	Extensive
Risks	Minimal	Low	Moderate	High
MDM LEVEL				4
*To qualify for a given type of MDM complexity, 2 of 3 elements in the table must be met or exceeded.				

History: None  
Examination: Comprehensive  
MDM: High  
Number of Key Components: 2 of 3  
99233

**CASE 1-13**

## 1-13A CRITICAL CARE

**Professional Services:** 99291 (Evaluation and Management, Critical Care), 99292 (Evaluation and Management, Critical Care)

**ICD-10-CM DX:** T51.0X1A (Table of Drugs and Chemicals, Alcohol, beverage, Poisoning, Accidental [Unintentional]), R06.82 (Tachypnea), F10.229 (Alcohol, intoxication [acute], with dependence), I10 (Hypertension), Z99.11 (Dependence, on, ventilator)

**RATIONALE:** This service is reported with critical care codes because the patient is critically ill. The service is reported based on 100 minutes. Code 99291 is reported for the first 60 minutes and 99292 for the additional 40 minutes. There was significant amount of lab data, chest x-ray, continuous monitoring, the physician began mechanical ventilation, the patient was intubated, and IV fluids were started. These services are included in the critical care codes and not reported separately.

If you reported a consultation rather than critical care, the code would be 99253. There is a note following the ventilator management codes 94002-94004 that directs the coder to not report the ventilator management codes with E/M codes, so the ventilation would not have been reported. The patient had been placed on mechanical ventilation and was unable to communicate for the history portion of the encounter. In these types of situations, the history component is waived and qualifies as a level 4 or comprehensive history level.

There were 3 constitutional elements examined: blood pressure, pulse (heart rate), and respiration that counts as 1 OS. There were 8 BAs examined: head (normocephalic, atraumatic), neck (supple), chest (symmetrical), extremities (arthritic changes, counts as 4), and abdomen (obese, soft, nontender). There were 5 OSs examined: ophthalmologic (conjunctivae, sclerae), respiratory (no rhonchi, crackles, wheezes), gastrointestinal (bowel sound), cardiovascular (no edema, both lower legs; pulses are fair; S1-4), and lymphatic (lymphadenopathy), which would ordinarily make this a level 4 or comprehensive examination; however, only OSs are counted for the comprehensive level. With a total of 6 OSs, this examination is a level 3 or detailed physical examination.

There was an extensive number of management options, a minimal amount of data to review (lab results), and a high risk of death to the patient if left untreated. This qualifies as a level 4 or high MDM.

Acute alcohol intoxication is a poisoning.

ICD-10-CM Guidelines for Coding and Reporting, Section I.C.19.5.d., state that if a harmful substance is ingested it is classified as a toxic effect, therefore, the appropriate code from categories T51-T65 is to be assigned. The Toxic Effect codes have categories for assigning intent, which include accidental/unintentional, intentional self-harm, assault, and undetermined. According to the note included in the category for Toxic Effects of Substances Chiefly Nonmedicinal as to Source (T51-T65), "When no intent is indicated code to accidental. Undetermined intent is only for use when there is specific documentation in the record that the intent of the toxic effect cannot be determined". Since the medical record does not contain any specific documentation regarding intent, T51.0X1A is assigned. The 7th character "A" indicates that this is the initial encounter. The Tabular note directs assigning additional code(s) for all associated manifestations of the toxic effect. A code is also to be assigned if a diagnosis of drug abuse or dependence on a substance is documented. Report the tachypnea (R06.82), the alcohol dependence with intoxication (F10.229) and hypertension (I10), as the report states it is only "fairly controlled". You can also report the ventilator support (Z99.11).

CHAPTER 1, CASE 1-13A

HISTORY ELEMENTS				Documented
<b>HISTORY OF PRESENT ILLNESS (HPI)</b>				
1. Location (site on body)				
2. Quality (characteristic: throbbing, sharp)				
3. Severity (1/10 or how intense)				X
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)				X
8. Associated signs and symptoms (what else is happening when it occurs)				
*Duration not in CPT as HPI Element	TOTAL LEVEL	Unobtainable	4	
<b>REVIEW OF SYSTEMS (ROS)</b>				
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				
14. Allergic/Immunologic				
	TOTAL LEVEL	Unobtainable	4	
<b>PAST, FAMILY, AND/OR SOCIAL HISTORY (PFSH)</b>				
1. Past illness, operations, injuries, treatments, and current medications				X
2. Family medical history for heredity and risk				X
3. Social activities, both past and present				X
	TOTAL LEVEL		3	
			4	
History Level	1	2	3	4
	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
HPI	Brief 1-3	Brief 1-3	Extended 4+	Extended 4+
ROS	None	Problem Pertinent 1	Extended 2-9	Complete 10+
PFSH	None	None	Pertinent 1	Complete 2-3
			HISTORY LEVEL	4

EXAMINATION ELEMENTS				Documented
<b>CONSTITUTIONAL (OS)</b>				
• Blood pressure, sitting				
• Blood pressure, lying				X
• Pulse				X
• Respirations				X
• Temperature				
• Height				
• Weight				
• General appearance				
	(Counts as only 1)	NUMBER	1	
<b>BODY AREAS (BA)</b>				
1. Head (including face)				X
2. Neck				X
3. Chest (including breasts and axillae)				X
4. Abdomen				X
5. Genitalia, groin, buttocks				
6. Back (including spine)				
7. Each extremity				XXXX
		NUMBER	8	
<b>ORGAN SYSTEMS (OS)</b>				
1. Ophthalmologic (eyes)				X
2. Otolaryngologic (ears, nose, mouth, throat)				
3. Cardiovascular				X
4. Respiratory				X
5. Gastrointestinal				X
6. Genitourinary				
7. Musculoskeletal				
8. Integumentary (skin)				
9. Neurologic				
10. Psychiatric				
11. Hematologic/Lymphatic/Immunologic				X
		NUMBER	5	
		TOTAL BA/OS	14(6)	
Exam Level	1	2	3	4
	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
	Limited to affected BA/OS	Limited to affected BA/OS & other related OS(s)	Extended of affected BA(s) & other related OS(s)	General multi-system (OSs only)
# of OS or BA	1	2-7 limited	2-7 extended	8+
			EXAMINATION LEVEL	3

MDM ELEMENTS				Documented
<b># OF DIAGNOSIS/MANAGEMENT OPTIONS</b>				
1. Minimal				
2. Limited				
3. Multiple				
4. Extensive				X
			LEVEL	4
<b>AMOUNT AND/OR COMPLEXITY OF DATA TO REVIEW</b>				
1. Minimal/None				
2. Limited				
3. Moderate				
4. Extensive				X
			LEVEL	4
<b>RISK OF COMPLICATION OR DEATH IF NOT TREATED</b>				
1. Minimal				
2. Low				
3. Moderate				
4. High				X
			LEVEL	4
MDM*	1	2	3	4
	Straightforward	Low	Moderate	High
Number of DX or management options	Minimal	Limited	Multiple	Extensive
Amount and/or complexity of data	Minimal/None	Limited	Moderate	Extensive
Risks	Minimal	Low	Moderate	High
			MDM LEVEL	4
*To qualify for a given type of MDM complexity, 2 of 3 elements in the table must be met or exceeded.				

History: Comprehensive  
Examination: Detailed  
MDM: High

Number of Key Components: 3 of 3

99253 or 99291, 99292 (See Rationale)

## CASE 1-14

### 1-14A ICU REPORT

### CASE 1-14

#### 1-14A ICU REPORT

**Professional Services:** 99291 (Evaluation and Management, Critical Care)

**ICD-10-CM DX:** I61.1 (Hemorrhage/hemorrhagic, intracranial, intracerebral [nontraumatic], hemisphere, cortical)

**RATIONALE:** The patient is critically ill with a poor prognosis and there is a high probability of further deterioration or death. There was extensive data (CT scan, ECG, labs, monitoring), intubation, and ventilation. This is a critical care service, which is based on the time spent with the patient, not the usual key components. However, if you did an audit form the services reflect a comprehensive level of history (unobtainable due to patient's condition), comprehensive examination with 10 BAs/OSs, and a high level of MDM.

The physician spent 60 minutes in critical care of the patient, which is correctly reported with 99291.

The diagnosis is as stated in the Assessment/Plan section of the report as left frontal lobe hemorrhage (I61.1).

## CASE 1-15

### 1-15A CRITICAL CARE

### CASE 1-15

#### 1-15A CRITICAL CARE

**Professional Services:** 99291 (Evaluation and Management, Critical Care), 99292 (Evaluation and Management, Critical Care)

**ICD-10-CM DX:** I42.6 (Cardiomyopathy, alcoholic), F10.188 (Abuse, alcohol, other specified disorder), I50.9 (Failure/failed, heart, congestive), I27.2 (Hypertension, pulmonary [artery] NEC), N18.9 (Insufficiency, renal, chronic)

**RATIONALE:** The medical record documents that the physician spent 90 minutes in the critical care of this patient. Critical care services are reported based on the time, not on the usual key components.

The diagnosis is as stated in the Assessment/Plan section of the report as alcoholic cardiomyopathy (I42.6), congestive heart failure (I50.9), pulmonary hypertension (I27.2), and chronic renal insufficiency (N18.9). A directive at I42.6 to code also presence of alcoholism, F10.— leading to F10.188, abuse, alcohol, other specified disorder.

**CASE 1-16**  
**1-16A CRITICAL CARE**  
**1-16B PROGRESS REPORT**  
**1-16C PROGRESS REPORT**

**CASE 1-16**

1-16A CRITICAL CARE, 1-16B PROGRESS REPORT, 1-16C PROGRESS REPORT

**Professional Services:** 99291 (Evaluation and Management, Critical Care), 99292 × 4 (Evaluation and Management, Critical Care)

**ICD-10-CM DX:** I46.2 (Arrest/arrested, cardiac, due to, cardiac condition), J96.90 (Failure/failed, respiration/respiratory), N17.9 (Failure/failed, renal, acute), I12.9 (Hypertension/hypertensive, due to, kidney, with, stage 1 through stage 4 chronic kidney disease), N18.9 (Disease/diseased, renal, chronic), J44.9 (Disease/diseased, pulmonary, chronic obstructive), E11.9 (Diabetes, type 2), I95.9 (Hypotension) as indicated on 1-16C, E87.5 (Hyperkalemia) as indicated on 1-16B, Z99.11 (Dependence, on, ventilator)

**RATIONALE:** The total time the physician spent on the critical care of the patient on this day is added together and coded as one unit of time. The physician spent a total of 175 minutes on the care of the patient: 90, 40, 45 minutes.

Report 1-16A indicates in the Assessment/Plan section of the report that the diagnoses are cardiopulmonary arrest, respiratory failure, COPD, and acute and chronic renal failure. Report 1-16C indicates hypotension. Report 1-16B indicates hyperkalemia. The patient is dependent on a ventilator, so that status is reported.

**CASE 1-17**  
**1-17A CRITICAL CARE ADMISSION**

**CASE 1-17**

1-17A CRITICAL CARE ADMISSION \_\_\_\_\_

**Professional Services:** 99291 (Evaluation and Management, Critical Care), 99292 × 2 (Evaluation and Management, Critical Care)

**ICD-10-CM DX:** I95.9 (Hypotension), J96.90 (Failure/failed, respiration/respiratory), I50.9 (Failure/failed, heart, congestive), N17.9 (Failure/failed, renal, acute)



**RATIONALE:** No audit sheet is necessary on this case, as the patient is in critical condition and critical care is provided. A total of 120 minutes was indicated in the medical record.

The diagnoses are stated in the first line of the report as hypotension and respiratory failure and that is the reason for the patient being admitted. Then within the Assessment/Plan section of the report, the physician indicates in point 2 that the patient has congestive heart failure and in point 3 acute renal failure. Note that hypertension and diabetes are also stated as the underlying problems; however, at this time these two conditions were not the reason the patient was admitted to the hospital and would not be coded by the physician coder.

In point 3 of the Assessment/Plan, the statement “Acute renal failure, **most likely** (this is a probable diagnosis) superimposed on top of underlying chronic renal failure secondary to the following: congestive heart failure/overload, hypertension, history of type 2 diabetes” indicates that the physician is considering various causes of the acute renal failure. But since these are not confirmed diagnoses, only the acute renal failure is reported.

In point 4 of the assessment plan, the physician orders blood glucose checks. There is no definitive statement that the patient currently has diabetes. In review of the patient’s past medical history (#3), the physician indicates that the patient’s insulin was discontinued (apparently some time ago) because his blood sugar was under control at that time. Therefore, E11.9 is not assigned.

## CASE 1-18 1-18A OFFICE VISIT

### CASE 1-18

#### 1-18A OFFICE VISIT

**Professional Services:** 99213 (Evaluation and Management, Office and Other Outpatient)

**ICD-10-CM DX:** E03.9 (Hypothyroidism)

**RATIONALE:** This patient is an established patient (noted in the first line of Subjective). The HPI included the timing (persistent), duration (yesterday), and associated signs and symptoms (dizziness and pills and food sticking in throat) for a total of 3 elements for a level 2 or expanded problem focused HPI. The ROS included only 1 system (endocrine—thyroid) for a level 2 or expanded problem focused ROS. PFSH elements included 1 element of past history (medication, Synthroid) for a level 3 or detailed level. This is an expanded problem focused history.

The examination included 3 constitutional elements of blood pressure, respiratory 20s, and general appearance (good health), which equals 1 OS. The 2 BAs are head (H in HEENT) and neck (supple). There are 3 OSs of lymphatic, eyes, and ear/nose/throat for a total of 6 BA/OS. This is a detailed examination.

The MDM included a limited number of diagnosis options; however, dizziness was a new problem to the examiner, a minimal amount of data to review, and a moderate level of risk to the patient (chronic illness with mild exacerbation or prescription drug management). This is a level 2 or low MDM.

The chief complaint is that of dizziness, but the physician’s diagnosis is stated in the Assessment section of the report and is stated to be hypothyroidism E03.9.

CHAPTER 1, CASE 1-18A

HISTORY ELEMENTS				Documented
<b>HISTORY OF PRESENT ILLNESS (HPI)</b>				
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)				X
5. Timing (when it occurs)				X
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)				X
*Duration not in CPT as HPI Element	TOTAL			3
	LEVEL			2
<b>REVIEW OF SYSTEMS (ROS)</b>				
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				X
13. Hematologic/Lymphatic				
14. Allergic/Immunologic				
	TOTAL			1
	LEVEL			2
<b>PAST, FAMILY, AND/OR SOCIAL HISTORY (PFSH)</b>				
1. Past illness, operations, injuries, treatments, and current medications				X
2. Family medical history for heredity and risk				
3. Social activities, both past and present				
	TOTAL			1
	LEVEL			3
History Level	1	2	3	4
	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
HPI	Brief 1-3	Brief 1-3	Extended 4+	Extended 4+
ROS	None	Problem Pertinent 1	Extended 2-9	Complete 10+
PFSH	None	None	Pertinent 1	Complete 2-3
	HISTORY LEVEL			2

EXAMINATION ELEMENTS				Documented
<b>CONSTITUTIONAL (OS)</b>				
• Blood pressure, sitting				X
• Blood pressure, lying				
• Pulse				
• Respirations				X
• Temperature				
• Height				
• Weight				
• General appearance				X
	(Counts as only 1)	NUMBER		1
<b>BODY AREAS (BA)</b>				
1. Head (including face)				X
2. Neck				X
3. Chest (including breasts and axillae)				
4. Abdomen				
5. Genitalia, groin, buttocks				
6. Back (including spine)				
7. Each extremity				
		NUMBER		2
<b>ORGAN SYSTEMS (OS)</b>				
1. Ophthalmologic (eyes)				X
2. Otolaryngologic (ears, nose, mouth, throat)				X
3. Cardiovascular				
4. Respiratory				
5. Gastrointestinal				
6. Genitourinary				
7. Musculoskeletal				
8. Integumentary (skin)				
9. Neurologic				
10. Psychiatric				
11. Hematologic/Lymphatic/Immunologic				X
		NUMBER		3
		TOTAL BA/OS		6
Exam Level	1	2	3	4
	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
	Limited to affected BA/OS	Limited to affected BA/OS & other related OS(s)	Extended of affected BA(s) & other related OS(s)	General multi-system (OSs only)
# of OS or BA	1	2-7 limited	2-7 extended	8+
	EXAMINATION LEVEL			3

MDM ELEMENTS				Documented
# OF DIAGNOSIS/MANAGEMENT OPTIONS				
1. Minimal				
2. Limited				X
3. Multiple				
4. Extensive				
LEVEL				2
AMOUNT AND/OR COMPLEXITY OF DATA TO REVIEW				Documented
1. Minimal/None				X
2. Limited				
3. Moderate				
4. Extensive				
LEVEL				1
RISK OF COMPLICATION OR DEATH IF NOT TREATED				Documented
1. Minimal				
2. Low				
3. Moderate				X
4. High				
LEVEL				3
MDM*	1	2	3	4
	Straightforward	Low	Moderate	High
Number of DX or management options	Minimal	Limited	Multiple	Extensive
Amount and/or complexity of data	Minimal/None	Limited	Moderate	Extensive
Risks	Minimal	Low	Moderate	High
MDM LEVEL				2
*To qualify for a given type of MDM complexity, 2 of 3 elements in the table must be met or exceeded.				

History: Expanded Problem Focused  
 Examination: Detailed  
 MDM: Low  
 Number of Key Components: 2 of 3  
 99213

**CASE 1-19**  
**1-19A OFFICE VISIT**  
**1-19B OFFICE VISIT**  
**1-19C CLINIC PROGRESS NOTE**

**CASE 1-19**

1-19A OFFICE VISIT \_\_\_\_\_

**Professional Services: 99203** (Evaluation and Management, Office and Other Outpatient)

**ICD-10-CM DX: J06.9** (Infection/infected/infective, respiratory, [acute] upper NOS), **R59.0** (Lymphadenopathy, localized)

**RATIONALE:** This is a new patient as stated in the second sentence of the first paragraph. The HPI included the location (right side of neck), duration (last week), modifying factors (nothing has reduced swelling), and associated signs and symptoms (upper respiratory infection) for a level 4 or comprehensive HPI. The ROS included the otolaryngologic (ENT part of HEENT), ophthalmologic (E part of HEENT), respiratory (lungs), cardiovascular (heart), gastrointestinal, and neurologic for a total of 6 elements or a detailed level ROS. The PFSH included the family, past, social (dog) medical history for a level 4 or comprehensive PFSH. This is a level 3 or detailed history.

The examination included the constitutional items of weight, general appearance (happy, alert), and height (length) for a total of 1 OS. The BAs of head (nontraumatic), back (spine straight), abdomen (masses, nontender), and neck were examined for a total of 4 BAs. There were 9 OSs reviewed: ophthalmologic (part of HEENT), otolaryngologic (part of HEENT), lymphatic (lymph node, cervical adenopathy), respiratory (lungs), cardiovascular, genitourinary (GUR, Tanner 1 female), integumentary (no erythema), gastrointestinal (bowel sounds), and neurologic. There were 14 BAs/OSs reviewed, which would ordinarily make this a level 4 or comprehensive examination; however, only OSs are counted for the comprehensive level. Without counting the BAs there are still 1 OS for the constitutional and 9 OSs, so this still is a comprehensive examination even without the BAs.

The MDM included moderate diagnoses or management options (new problem, labs ordered), minimal data to review (labs), and moderate risk (acute, uncomplicated; but prescription was prescribed) to the patient for a level 3 moderate MDM.

The diagnosis is stated in the Impression section as lymphadenopathy is secondary to pharyngitis or upper respiratory infection.

CHAPTER 1, CASE 1-19A

HISTORY ELEMENTS				Documented
<b>HISTORY OF PRESENT ILLNESS (HPI)</b>				
1. Location (site on body)				X
2. Quality (characteristic: throbbing, sharp)				
3. Severity (1/10 or how intense)				
4. Duration* (how long for problem or episode)				X
5. Timing (when it occurs)				
6. Context (under what circumstances does it occur)				
7. Modifying factors (what makes it better or worse)				X
8. Associated signs and symptoms (what else is happening when it occurs)				X
*Duration not in CPT as HPI Element	TOTAL			4
	LEVEL			4
<b>REVIEW OF SYSTEMS (ROS)</b>				
1. Constitutional (e.g., weight loss, fever)				
2. Ophthalmologic (eyes)				X
3. Otolaryngologic (ears, nose, mouth, throat)				X
4. Cardiovascular				X
5. Respiratory				X
6. Gastrointestinal				X
7. Genitourinary				
8. Musculoskeletal				
9. Integumentary (skin and/or breasts)				
10. Neurological				X
11. Psychiatric				
12. Endocrine				
13. Hematologic/Lymphatic				
14. Allergic/Immunologic				
	TOTAL			6
	LEVEL			3
<b>PAST, FAMILY, AND/OR SOCIAL HISTORY (PFSH)</b>				
1. Past illness, operations, injuries, treatments, and current medications				X
2. Family medical history for heredity and risk				X
3. Social activities, both past and present				X
	TOTAL			3
	LEVEL			4
History Level	1	2	3	4
	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
HPI	Brief 1-3	Brief 1-3	Extended 4+	Extended 4+
ROS	None	Problem Pertinent	Extended 2-9	Complete 10+
PFSH	None	None	Pertinent 1	Complete 2-3
	HISTORY LEVEL			3

EXAMINATION ELEMENTS				Documented
<b>CONSTITUTIONAL (OS)</b>				
• Blood pressure, sitting				
• Blood pressure, lying				
• Pulse				
• Respirations				
• Temperature				
• Height				X
• Weight				X
• General appearance				X
	(Counts as only 1)	NUMBER		1
<b>BODY AREAS (BA)</b>				
1. Head (including face)				X
2. Neck				X
3. Chest (including breasts and axillae)				
4. Abdomen				X
5. Genitalia, groin, buttocks				
6. Back (including spine)				X
7. Each extremity				
		NUMBER		4
<b>ORGAN SYSTEMS (OS)</b>				
1. Ophthalmologic (eyes)				X
2. Otolaryngologic (ears, nose, mouth, throat)				X
3. Cardiovascular				X
4. Respiratory				X
5. Gastrointestinal				X
6. Genitourinary				X
7. Musculoskeletal				
8. Integumentary (skin)				X
9. Neurologic				X
10. Psychiatric				
11. Hematologic/Lymphatic/Immunologic				X
		NUMBER		9
		TOTAL BA/OS		14(10)
Exam Level	1	2	3	4
	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
	Limited to affected BA/OS	Limited to affected BA/OS & other related OS(s)	Extended of affected BA(s) & other related OS(s)	General multi-system (OSs only)
# of OS or BA	1	2-7 limited	2-7 extended	8+
	EXAMINATION LEVEL			4

MDM ELEMENTS				Documented
# OF DIAGNOSIS/MANAGEMENT OPTIONS				
1. Minimal				
2. Limited				
3. Multiple				X
4. Extensive				
LEVEL				3
AMOUNT AND/OR COMPLEXITY OF DATA TO REVIEW				Documented
1. Minimal/None				X
2. Limited				
3. Moderate				
4. Extensive				
LEVEL				1
RISK OF COMPLICATION OR DEATH IF NOT TREATED				Documented
1. Minimal				
2. Low				
3. Moderate				X
4. High				
LEVEL				3
MDM*	1	2	3	4
	Straightforward	Low	Moderate	High
Number of DX or management options	Minimal	Limited	Multiple	Extensive
Amount and/or complexity of data	Minimal/None	Limited	Moderate	Extensive
Risks	Minimal	Low	Moderate	High
MDM LEVEL				3
*To qualify for a given type of MDM complexity, 2 of 3 elements in the table must be met or exceeded.				

History: Detailed  
 Examination: Comprehensive  
 MDM: Moderate  
 Number of Key Components: 3 of 3  
 99203

1-19B OFFICE VISIT

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**Professional Services: 99213** (Evaluation and Management, Office and Other Outpatient)

**ICD-10-CM DX: I88.9** (Lymphadenitis)

**RATIONALE:** The patient is returning to the office for a follow-up of the initial service, which makes this an established patient for this service. The HPI included the location (right side of neck), modifying factor (treatment with antibiotic), and associated signs and symptoms (lump is not sore) for a level 2 HPI. The ROS included 2 systems: gastrointestinal (diarrhea), and respiratory (no cold symptoms with congestion) for a level 3 or detailed ROS. None of the PFSH elements were reviewed for a level 2 or expanded problem focused PFSH. This is an expanded problem focused history (level 2).

The examination included 1 BA abdomen (soft, no masses) and 5 OSs: otolaryngologic (tympanic membranes [TMs], sinus, and pharynx), lymphatic (lymph nodes), respiratory (chest), gastrointestinal (no organomegaly), and cardiovascular (heart) for a total of 6 elements or a level 2 or expanded problem focused examination. Level 2 was chosen over level 3 because there was only one extended examination element, that of the lymph system, which is the chief complaint. Even if a level 3 were assigned, it would not alter the final code assignment.

The MDM contained a limited number of diagnoses or management options, no data to review, and a low level of risk to the patient. This is a low complexity of MDM.

The diagnosis is stated in the Impression section of the report as being lymphadenitis.

CHAPTER 1, CASE 1-19B

HISTORY ELEMENTS				Documented
<b>HISTORY OF PRESENT ILLNESS (HPI)</b>				
1. Location (site on body)				X
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)				X
8. Associated signs and symptoms (what else is happening when it occurs)				X
*Duration not in CPT as HPI Element	TOTAL			3
	LEVEL			2
<b>REVIEW OF SYSTEMS (ROS)</b>				
1. Constitutional (e.g., weight loss, fever)				
2. Ophthalmologic (eyes)				
3. Otolaryngologic (ears, nose, mouth, throat)				
4. Cardiovascular				
5. Respiratory				X
6. Gastrointestinal				X
7. Genitourinary				
8. Musculoskeletal				
9. Integumentary (skin and/or breasts)				
10. Neurological				
11. Psychiatric				
12. Endocrine				
13. Hematologic/Lymphatic				
14. Allergic/Immunologic				
	TOTAL			2
	LEVEL			3
<b>PAST, FAMILY, AND/OR SOCIAL HISTORY (PFSH)</b>				
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			0
	LEVEL			2
History Level	1	2	3	4
	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
HPI	Brief 1-3	Brief 1-3	Extended 4+	Extended 4+
ROS	None	Problem Pertinent 1	Extended 2-9	Complete 10+
PFSH	None	None	Pertinent 1	Complete 2-3
	HISTORY LEVEL			2

EXAMINATION ELEMENTS				Documented
<b>CONSTITUTIONAL (OS)</b>				
• Blood pressure, sitting				
• Blood pressure, lying				
• Pulse				
• Respirations				
• Temperature				
• Height				
• Weight				
• General appearance				
	(Counts as only 1)	NUMBER		0
<b>BODY AREAS (BA)</b>				
1. Head (including face)				
2. Neck				
3. Chest (including breasts and axillae)				
4. Abdomen				X
5. Genitalia, groin, buttocks				
6. Back (including spine)				
7. Each extremity				
		NUMBER		1
<b>ORGAN SYSTEMS (OS)</b>				
1. Ophthalmologic (eyes)				
2. Otolaryngologic (ears, nose, mouth, throat)				X
3. Cardiovascular				X
4. Respiratory				X
5. Gastrointestinal				X
6. Genitourinary				
7. Musculoskeletal				
8. Integumentary (skin)				
9. Neurologic				
10. Psychiatric				
11. Hematologic/Lymphatic/Immunologic				X
		NUMBER		5
		TOTAL BA/OS		6
Exam Level	1	2	3	4
	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
	Limited to affected BA/OS	Limited to affected BA/OS & other related OS(s)	Extended of affected BA(s) & other related OS(s)	General multi-system (OSs only)
# of OS or BA	1	2-7 limited	2-7 extended	8+
	EXAMINATION LEVEL			2

MDM ELEMENTS				Documented
# OF DIAGNOSIS/MANAGEMENT OPTIONS				
1. Minimal				
2. Limited				X
3. Multiple				
4. Extensive				
LEVEL				2
AMOUNT AND/OR COMPLEXITY OF DATA TO REVIEW				
1. Minimal/None				X
2. Limited				
3. Moderate				
4. Extensive				
LEVEL				1
RISK OF COMPLICATION OR DEATH IF NOT TREATED				
1. Minimal				
2. Low				X
3. Moderate				
4. High				
LEVEL				2
MDM*	1	2	3	4
	Straightforward	Low	Moderate	High
Number of DX or management options	Minimal	Limited	Multiple	Extensive
Amount and/or complexity of data	Minimal/None	Limited	Moderate	Extensive
Risks	Minimal	Low	Moderate	High
MDM LEVEL				2
*To qualify for a given type of MDM complexity, 2 of 3 elements in the table must be met or exceeded.				

History: Expanded Problem Focused  
Examination: Expanded Problem Focused  
MDM: Low

Number of Key Components: 2 of 3

99213

1-19C CLINIC PROGRESS NOTE

**Professional Services: 99213** (Evaluation and Management, Office or Other Outpatient)

**ICD-10-CM DX: J06.9** (Infection/infected/infective, respiratory, upper NOS),  
**J02.9** (Pharyngitis)

**RATIONALE:** This is an established patient as stated in the first sentence of the report. The HPI included duration (past couple days), associated signs and symptoms (emesis, low-grade temp, cough, diarrhea), and timing (this AM, past 6 hours, intermittent) for a level 2 or expanded problem focused HPI. The ROS included the 2 systems of gastrointestinal (no diarrhea), and immunologic (immunizations). None of the PFSH elements were reviewed for a level 2. This is a level 2 or an expanded problem focused history.

The examination included 2 constitutional elements of general appearance (alert) and temperature (afebrile), which counts as 1 OS. There is 1 BA of neck (supple). There are 6 OSs of ophthalmologic (eyes), otolaryngologic (tympanic membranes, nose, pharynx), respiratory (lungs), gastrointestinal (benign), lymphatic (lymphadenopathy), and cardiovascular (heart) for a total of 8 BAs/OSs, which would ordinarily make this a level 4 or comprehensive examination; however, only OSs are counted for the comprehensive level. With a total of 7 OSs, this examination is a level 3 or detailed physical examination.

The MDM included limited diagnoses or management options (cold symptoms), minimal amount of data to review (labs), and low risk to the patient, making this a low complexity of MDM.

The diagnosis is as stated in the Impression section of the report as upper respiratory infection (URI) and pharyngitis.



CHAPTER 1, CASE 1-19C

HISTORY ELEMENTS				Documented
<b>HISTORY OF PRESENT ILLNESS (HPI)</b>				
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)				X
5. Timing (when it occurs)				X
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)				X
*Duration not in CPT as HPI Element	TOTAL			3
	LEVEL			2
<b>REVIEW OF SYSTEMS (ROS)</b>				
1. Constitutional (e.g., weight loss, fever)				
2. Ophthalmologic (eyes)				
3. Otolaryngologic (ears, nose, mouth, throat)				
4. Cardiovascular				
5. Respiratory				
6. Gastrointestinal				X
7. Genitourinary				
8. Musculoskeletal				
9. Integumentary (skin and/or breasts)				
10. Neurological				
11. Psychiatric				
12. Endocrine				
13. Hematologic/Lymphatic				
14. Allergic/Immunologic				X
	TOTAL			2
	LEVEL			3
<b>PAST, FAMILY, AND/OR SOCIAL HISTORY (PFSH)</b>				
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			0
	LEVEL			2
History Level	1	2	3	4
	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
HPI	Brief 1-3	Brief 1-3	Extended 4+	Extended 4+
ROS	None	Problem Pertinent 1	Extended 2-9	Complete 10+
PFSH	None	None	Pertinent 1	Complete 2-3
	HISTORY LEVEL			2

EXAMINATION ELEMENTS				Documented
<b>CONSTITUTIONAL (OS)</b>				
• Blood pressure, sitting				
• Blood pressure, lying				
• Pulse				
• Respirations				
• Temperature				X
• Height				
• Weight				
• General appearance				X
	(Counts as only 1)	NUMBER		1
<b>BODY AREAS (BA)</b>				
1. Head (including face)				
2. Neck				X
3. Chest (including breasts and axillae)				
4. Abdomen				
5. Genitalia, groin, buttocks				
6. Back (including spine)				
7. Each extremity				
		NUMBER		1
<b>ORGAN SYSTEMS (OS)</b>				
1. Ophthalmologic (eyes)				X
2. Otolaryngologic (ears, nose, mouth, throat)				X
3. Cardiovascular				X
4. Respiratory				X
5. Gastrointestinal				X
6. Genitourinary				
7. Musculoskeletal				
8. Integumentary (skin)				
9. Neurologic				
10. Psychiatric				
11. Hematologic/Lymphatic/Immunologic				X
		NUMBER		6
		TOTAL BA/OS		8(7)
Exam Level	1	2	3	4
	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
	Limited to affected BA/OS	Limited to affected BA/OS & other related OS(s)	Extended of affected BA(s) & other related OS(s)	General multi-system (OSs only)
# of OS or BA	1	2-7 limited	2-7 extended	8+
	EXAMINATION LEVEL			3

MDM ELEMENTS				Documented
# OF DIAGNOSIS/MANAGEMENT OPTIONS				
1. Minimal				
2. Limited				X
3. Multiple				
4. Extensive				
LEVEL				2
AMOUNT AND/OR COMPLEXITY OF DATA TO REVIEW				
1. Minimal/None				X
2. Limited				
3. Moderate				
4. Extensive				
LEVEL				1
RISK OF COMPLICATION OR DEATH IF NOT TREATED				
1. Minimal				
2. Low				X
3. Moderate				
4. High				
LEVEL				2
MDM*	1	2	3	4
	Straightforward	Low	Moderate	High
Number of DX or management options	Minimal	Limited	Multiple	Extensive
Amount and/or complexity of data	Minimal/None	Limited	Moderate	Extensive
Risks	Minimal	Low	Moderate	High
MDM LEVEL				2
*To qualify for a given type of MDM complexity, 2 of 3 elements in the table must be met or exceeded.				

History: Expanded Problem Focused  
 Examination: Detailed  
 MDM: Low  
 Number of Key Components: 2 of 3  
 99213

**CASE 1-20**

## 1-20A OBSERVATION

**Professional Services:** 99218 (Evaluation and Management, Hospital Services, Observation Care)

**ICD-10-CM DX:** E86.9 (Depletion, volume NOS), R19.7 (Diarrhea/diarrheal), E87.2 (Acidosis, metabolic NEC), I12.9 (Hypertension/hypertensive, kidney, with, stage 1 through stage 4 chronic kidney disease), N18.9 (Disease, kidney, chronic), M32.14 (Lupus, nephritis [chronic])

**RATIONALE:** The HPI was a level 4 and contains the 5 elements of quality (loose, explosive), timing (4 times per hour), duration (since 8 PM last night), associated signs and symptoms (cramping), and context (renal failure). The ROS is level 4 (10 elements) and includes constitutional (general), ophthalmologic (eyes), otolaryngologic (ENT), cardiovascular (cardiac), respiratory, gastrointestinal (GI), genitourinary (GU), integumentary (skin), neurologic (neuro), and endocrine. All three of the PFSH elements were reviewed making this a level 4 PFSH. The HPI, ROS, and PFSH make this a level 4 or comprehensive history.

The examination included the constitutional elements of blood pressure, respirations, temperature (afebrile), and general (looks dry, no distress) equaling 1 OS. The body areas were abdomen (soft, nontender) and back (spine straight) for 2 BAs. There were 6 OSs of otolaryngologic (ENT), cardiovascular (leg edema and cardiac exam), respiratory (lungs), neurologic, musculoskeletal (normal gait), and lymphatic (no cervical lymphadenopathy) for a total of 9 BAs/OSs, which would ordinarily make this a level 4 or comprehensive examination; however, only OSs are counted for the comprehensive level. With a total of 7 OSs, this examination is a level 3 or detailed physical examination.

The MDM elements included extensive diagnosis/management options, extensive data to review (multiple labs, ordered renal ultrasound, abdominal x-ray, MRA being ordered, O<sub>2</sub> sats), and a high level of risk to the patient making this a high MDM or level 4.

The diagnoses are stated in the Reason for Admission section of the report as diarrhea and volume depletion. The primary reason the patient is admitted is due to the volume depletion and as such this is the first-listed or primary diagnosis. There is a statement in the Impression section of the report that this diarrhea is probably caused by some infection, but that statement is not coded as it is only a probability at the point in time that the physician dictated the report. This is an outpatient visit (observation status is an outpatient status) and would be coded using the outpatient coding guidelines. We are only able to code diagnoses that are definite. We are not able to code questionable, suspected diagnoses.

Under the Impression section of the report, the third-listed point indicates acidosis and is reported with E87.2. The fourth-listed point is chronic renal failure related to lupus nephritis. ICD-10-CM lists only one code to describe lupus nephritis, M32.14.

The chronic renal failure is reported with the hypertension combination code I12.9. The instructional notes for category I12 indicate to code also the stage of chronic kidney disease. Since it is not known in this case the stage of renal failure, N18.9 would be assigned for unspecified.

CHAPTER 1, CASE 1-20A

HISTORY ELEMENTS				Documented
<b>HISTORY OF PRESENT ILLNESS (HPI)</b>				
1. Location (site on body)				
2. Quality (characteristic: throbbing, sharp)				X
3. Severity (1/10 or how intense)				
4. Duration* (how long for problem or episode)				X
5. Timing (when it occurs)				X
6. Context (under what circumstances does it occur)				X
7. Modifying factors (what makes it better or worse)				
8. Associated signs and symptoms (what else is happening when it occurs)				X
*Duration not in CPT as HPI Element	TOTAL			5
	LEVEL			4
<b>REVIEW OF SYSTEMS (ROS)</b>				
1. Constitutional (e.g., weight loss, fever)				X
2. Ophthalmologic (eyes)				X
3. Otolaryngologic (ears, nose, mouth, throat)				X
4. Cardiovascular				X
5. Respiratory				X
6. Gastrointestinal				
7. Genitourinary				X
8. Musculoskeletal				
9. Integumentary (skin and/or breasts)				X
10. Neurological				X
11. Psychiatric				
12. Endocrine				X
13. Hematologic/Lymphatic				
14. Allergic/Immunologic				
	TOTAL			10
	LEVEL			4
<b>PAST, FAMILY, AND/OR SOCIAL HISTORY (PFSH)</b>				
1. Past illness, operations, injuries, treatments, and current medications				X
2. Family medical history for heredity and risk				X
3. Social activities, both past and present				X
	TOTAL			3
	LEVEL			4
History Level	1	2	3	4
	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
HPI	Brief 1-3	Brief 1-3	Extended 4+	Extended 4+
ROS	None	Problem Pertinent 1	Extended 2-9	Complete 10+
PFSH	None	None	Pertinent 1	Complete 2-3
	HISTORY LEVEL			4

EXAMINATION ELEMENTS				Documented
<b>CONSTITUTIONAL (OS)</b>				
• Blood pressure, sitting				
• Blood pressure, lying				X
• Pulse				
• Respirations				X
• Temperature				X
• Height				
• Weight				
• General appearance				X
(Counts as only 1) NUMBER				1
<b>BODY AREAS (BA)</b>				
1. Head (including face)				
2. Neck				
3. Chest (including breasts and axillae)				
4. Abdomen				X
5. Genitalia, groin, buttocks				
6. Back (including spine)				X
7. Each extremity				
NUMBER				2
<b>ORGAN SYSTEMS (OS)</b>				
1. Ophthalmologic (eyes)				
2. Otolaryngologic (ears, nose, mouth, throat)				X
3. Cardiovascular				X
4. Respiratory				X
5. Gastrointestinal				
6. Genitourinary				
7. Musculoskeletal				X
8. Integumentary (skin)				
9. Neurologic				X
10. Psychiatric				
11. Hematologic/Lymphatic/Immunologic				X
NUMBER				6
TOTAL BA/OS				9(7)
Exam Level	1	2	3	4
	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
	Limited to affected BA/OS	Limited to affected BA/OS & other related OS(s)	Extended of affected BA(s) & other related OS(s)	General multi-system (OSs only)
# of OS or BA	1	2-7 limited	2-7 extended	8+
EXAMINATION LEVEL				3

MDM ELEMENTS					Documented
<b># OF DIAGNOSIS/MANAGEMENT OPTIONS</b>					
1. Minimal					
2. Limited					
3. Multiple					
4. Extensive					X
LEVEL					4
<b>AMOUNT AND/OR COMPLEXITY OF DATA TO REVIEW</b>					
1. Minimal/None					
2. Limited					
3. Moderate					
4. Extensive					X
LEVEL					4
<b>RISK OF COMPLICATION OR DEATH IF NOT TREATED</b>					
1. Minimal					
2. Low					
3. Moderate					
4. High					X
LEVEL					4
MDM*	1	2	3	4	
	Straightforward	Low	Moderate	High	
Number of DX or management options	Minimal	Limited	Multiple	Extensive	
Amount and/or complexity of data	Minimal/None	Limited	Moderate	Extensive	
Risks	Minimal	Low	Moderate	High	
MDM LEVEL					4
*To qualify for a given type of MDM complexity, 2 of 3 elements in the table must be met or exceeded.					

History: Comprehensive  
 Examination: Detailed  
 MDM: High  
 Number of Key Components: 3 of 3  
 99218

*Volume depletion and dehydration are diagnoses that are often not well documented by physicians. Note the reference to “She was thought to be dehydrated in the ER and was admitted” and the statement about the tongue being dry and the administration of IV fluids. Query the physician about dehydration.*

**CASE 1-21**  
**1-21A NEWBORN CARE**

**CASE 1-21**

1-21A NEWBORN CARE \_\_\_\_\_

**Professional Services:** 1/1: 99460, 1/2: 99461, 1/3: 99461-25, 1/4: 99461 (Evaluation and Management, Newborn Care), 1/3: 54150 (Circumcision, Surgical Excision, Neonate), 1/5: 99238 (Evaluation and Management, Hospital, Discharge)

**ICD-10-CM DX:** Z38.01 (Newborn, single, born in hospital, by cesarean)

**RATIONALE:** On 1/1, the service provided was the initial normal newborn history and examination. On 1/2, 1/3, and 1/4 the services were subsequent hospital care services. The -25 modifier is added to the 1/3 E/M to show that it was distinct and separate from the circumcision done on the same day. The circumcision was performed on 1/3 and is reported in addition to the E/M services. On 1/5 the newborn was discharged from the hospital, and the physician reported the discharge services with 99238.

The diagnosis code Z38.01 reports a single, liveborn infant, born in the hospital (fourth digit 0), that was delivered by cesarean (fifth digit 1). Some may code Z41.2 for a routine circumcision done in the absence of any medical problem; however, the only time Z41.2 would usually be used is when a male patient was seen only for a circumcision without medical indication. But this is a newborn record, and the procedure is frequently performed in the absence of any medical indication.

## CASE 1-22

## 1-22A HOSPITAL SERVICES

## 1-22B NICU PROGRESS REPORT

## 1-22C NICU PROGRESS REPORT

## 1-22D NICU PROGRESS REPORT

## CASE 1-22

## 1-22A HOSPITAL SERVICES

**Professional Services: 99464** (Newborn Care, Attendance at Delivery), **99468** (Neonatal Critical Care, Initial)

**ICD-10-CM DX: P22.0** (Hyaline membrane [disease] [newborn]), **P07.17** (Low birth weight, with weight of, 1750-1999 grams), **P07.33** (Preterm newborn [infant] gestational age, 30 completed weeks), **P71.8** (Hypermagnesemia, neonatal), **Z05.1** (Observation [for], suspected, rule out, condition), **Z38.01** (Newborn, born in hospital, by cesarean)

**RATIONALE:** The pediatrician was in attendance at delivery (99464) as stated at the beginning of the fourth paragraph of the report (“I did attend the delivery...”). The CPT instructional notes in the inpatient neonatal critical care section states that 99464 can be reported on the same day as and in addition to critical care. The infant was immediately transferred to the neonatal intensive care unit where the pediatrician provided the initial care (99468), as stated at the end of the fourth paragraph. In the Plan section of the report, there is an indication that the infant was intubated, but this service is bundled into 99468 and would not be reported separately.

The diagnoses are stated at the end of the report in the Impression section. The hyaline membrane disease (#2 in the Impression) is reported with P22.0. The prematurity with low birth weight (P07.17) is based on P07.1 for “Other low birth weight newborn”, and the fifth character of “7” (1750-1999 grams) because the infant is 1808 grams. The gestation is reported with P07.33 for 30 completed weeks of gestation, Z38.01 (Newborn, born in hospital, by cesarean), and P71.8 (Hypermagnesemia, neonatal). The observation for suspected sepsis is reported with Z05.1.

## 1-22B NICU PROGRESS REPORT

**Professional Services: 99469** (Neonatal Critical Care, Subsequent)

**ICD-10-CM DX: P22.0** (Hyaline membrane [disease] [newborn]), **P07.17** (Low birth weight, newborn with weight of, 1750-1999 grams), **P07.33** (Preterm, newborn [infant] gestational age, 30 completed weeks), **P71.8** (Hypermagnesemia, neonatal), **Z03.89** (Observation [for], suspected, rule out, condition), **Z38.01** (Newborn, born in hospital, by cesarean)

**RATIONALE:** Code 99469 reports a subsequent neonatal intensive care service.

Point 2 of the Impressions/Recommendations section of the report indicates hyaline membrane disease (P22.0). The thrombocytopenia is stated in Point 5 and is reported with P61.0. Point 7 indicates that the infant was premature, which is reported with P05.07. Point 4 indicates hyperbilirubinemia (P59.0). The codes for prematurity (P05.07) and gestational age (P07.33) are assigned per the impression (#1) and the exam.

1-22C NICU PROGRESS REPORT \_\_\_\_\_

**Professional Services: 99469** (Neonatal Critical Care, Subsequent)

**ICD-10-CM DX: P22.0** (Hyaline membrane [disease] [newborn]), **P07.17** (Low birth weight, newborn with weight of, 1750-1999 grams), **P07.33** (Preterm newborn [infant] gestational age, 30 completed weeks), **P61.0** (Thrombocytopenia/thrombocytopenic, neonatal, transitory), **P59.0** (Jaundice, due to or associated with, preterm delivery), **Q25.0** (Patent ductus arteriosus or Botallo's)

**RATIONALE:** A subsequent neonatal intensive care was provided and reported with 99469.

The diagnoses to report are stated in the Impressions/Recommendations section of the report. The infant continues to have hyaline membrane disease (Point 2, P22.0). Premature (Point 1, P07.17), gestational age (Point 1, P07.33), thrombocytopenia (P61.0), and hyperbilirubinemia of a premature neonate (P59.0). Without careful reading of the Index and the Tabular, the student may respond with P59.9, which is hyperbilirubinemia of a newborn, but there is a specific code for that of a premature neonate. The patent, ductus arteriosus condition was discovered and will need to be treated. Q25.0 is assigned to report this finding.

1-22D NICU PROGRESS REPORT \_\_\_\_\_

**Professional Services: 99469** (Neonatal Critical Care, Subsequent)

**ICD-10-CM DX: P22.0** (Hyaline membrane [disease] [newborn]), **P07.17** (Low birth weight, newborn with weight of, 1750-1999 grams), **P07.33** (Preterm newborn [infant] gestational age, 30 completed weeks), **P61.0** (Thrombocytopenia/thrombocytopenic, neonatal, transitory), **P59.0** (Jaundice, due to or associated with, preterm delivery), **Q25.0** (Patent ductus arteriosus or Botallo's)

**RATIONALE:** The service is a subsequent neonatal intensive care reported with 99469.

The diagnoses continue to be hyaline membrane disease (P22.0). Immaturity, worsening thrombocytopenia requiring transfusion, and hyperbilirubinemia are confirmed and reported. There is an additional indication in Point 3 that there is patent ductus arteriosus, which is reported with Q25.0. The weight loss indicated in Point 9 is reported within the code for the immaturity in P07.17 and does not require an additional code.

## CASE 1-23

1-23A OFFICE VISIT

1-23B OFFICE VISIT

1-23C OFFICE VISIT

## CASE 1-23

1-23A OFFICE VISIT

**Professional Services: 99395** (Evaluation and Management, Preventive Services)**ICD-10-CM DX: Z00.00** (Examination, medical, general [adult]), **E03.9** (Hypothyroidism), **E66.3** (Overweight)

**RATIONALE:** The codes from the Preventive Medicine Services are based on the new or established patient and then subdivided based on the age of the patient. This was an established patient (stated in first sentence) who is 30 years old (stated in the first sentence).

The diagnosis code Z00.00 is the primary reason the service was provided (Pap and physical). The Z00.00 code includes the general medical and the gynecologic examination, so you would not code Z01.419 for a gynecologic portion of the examination. Then codes E03.9 for the hypothyroidism and E66.3 for the obesity, as both these issues were addressed during the physical exam. Preventive Medicine codes are intended to be used to identify comprehensive services, not a single-system examination, such as an annual gynecologic examination.

1-23B OFFICE VISIT

**Professional Services: 99395** (Evaluation and Management, Preventive Services)**ICD-10-CM DX: Z00.00** (Examination, medical [adult]), **E03.9** (Hypothyroidism), **E66.3** (Overweight)

**RATIONALE:** The patient is an established patient as stated in the first line of the report and is 31 years old. Notice the chief complaint states “checkup,” but the subjective part of the note clarifies that this is an annual exam. The content of the history, exam, and plan is multisystem and preventive in nature. Preventive service is based on whether it is a new or established patient and the age of the patient.

The diagnosis code is the reason for the service, and in this case the reason is a health checkup without any complaints as represented in Z00.00.

1-23C OFFICE VISIT

**Professional Services: 99395** (Evaluation and Management, Preventive Services)**ICD-10-CM DX: Z02.0** (Examination, medical [adult], admission to, school), **E03.9** (Hypothyroidism)



**RATIONALE:** The patient is an established patient (seen earlier this month) and is 32 years old. Preventive service is based on whether it is a new or established patient and the age of the patient.

The Z codes are reported as the stated purposes of the physical, which was a college physical (Z02.0) and is due for her annual gynecological examination. The (Z01.419) is not separately reported as it is included in the Z02.0 code as part of the general medical exam. Also, hypothyroidism was assessed and is reported (E03.9).

**CASE 1-24**  
**1-24A OFFICE VISIT**

**CASE 1-24**

1-24A OFFICE VISIT \_\_\_\_\_

**Professional Services: 99396** (Evaluation and Management, Preventive Services)

**ICD-10-CM DX: Z00.00** (Examination, medical, general [adult]), **I10** (Hypertension), **F17.210** (Dependence, drug, nicotine, cigarettes)

**RATIONALE:** This 54-year-old is an established patient as stated in the first line of the report. He is in for his annual checkup with no complaints. Preventive services are based on whether it is a new or established patient and the age of the patient.

The diagnosis code is the reason for the service, and in this case the reason is a health checkup without any complaints as represented in Z00.00. The hypertension and tobacco dependency are indicated and therefore reported.

**CASE 1-25**  
**1-25A OFFICE VISIT**

**CASE 1-25**

1-25A OFFICE VISIT \_\_\_\_\_

**Professional Services: 99392** (Evaluation and Management, Preventive Services)

**ICD-10-CM DX: Z00.129** (Examination, child care [over 28 days old])

**RATIONALE:** The child is 1 year old and is an established patient as stated in the report. The examination is of a routine healthy child Z00.129.

**CASE 1-26**  
**1-26A OFFICE VISIT**

**CASE 1-26**

1-26A OFFICE VISIT \_\_\_\_\_

**Professional Services: 99396** (Preventive Medicine, Established Patient)

**ICD-10-CM DX: Z01.419** (Examination, gynecological)

**RATIONALE:** *The patient is a 41-year-old, established patient (report states she was in 2 weeks ago). Preventive services are based on whether it is a new or established patient and the age of the patient.*

*The reason for the visit is a pelvic and Pap. No other areas were examined. Z01.419 reports the pelvic exam and Pap smear.*

# Evaluation and Management Services

## AUDIT REPORT 1.1 HOSPITAL SERVICES

### Incorrect code: 99222

**RATIONALE:** There were 4 HPI elements: location (chest), quality (sudden [SOB]), timing (getting ready for bed), and associated signs and symptoms (SOB, no chest pain, neck, jaw pain, pulmonary edema) for a level 4 or comprehensive HPI. There were 10 ROS: Constitutional (pale), ophthalmologic, otolaryngologic, cardiovascular, gastrointestinal, genitourinary, musculoskeletal, respiratory (could not get her breath), integumentary, and neurologic, for a level 4 or comprehensive ROS. All 3 of the PFSH elements were noted for a level 4 or comprehensive PFSH. This is a level 4 or comprehensive history.

The examination included 4 constitutional elements: blood pressure (in examination area and in the first paragraph of report), pulse, general appearance (pale), and respiration for 1 OS. The temperature does not count as there was no specific degree given. There was 1 BA of abdomen (obese, nontender). There were 4 OSs: cardiovascular (jugular venous pressure, neck vein distended, extremity edema), genitourinary (light urine), gastrointestinal (no organomegaly), and respiratory (lungs). There was a total of 6 BAs/OSs for a level 3 or detailed examination. This Initial Hospital Care code requires that all 3 key components meet or exceed the stated requirements. Left ventricular hypertrophy and mitral regurgitation are not reported since the documentation states “probably”. Hypoxia and pulmonary edema are signs and symptoms associated with congestive heart failure and would not be additionally coded.

The MDM contained extensive diagnoses/management options, limited data to review (x-ray, lab), and a high level of risk. This is a level 4 or high MDM.

The comprehensive history, detailed exam, and high MDM support 99221.

## CHAPTER 1, AUDIT REPORT 1.1

HISTORY ELEMENTS		Documented		
HISTORY OF PRESENT ILLNESS (HPI)				
1. Location (site on body)		X		
2. Quality (characteristic: throbbing, sharp)		X		
3. Severity (1/10 or how intense)				
4. Duration* (how long for problem or episode)				
5. Timing (when it occurs)		X		
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)		X		
*Duration not in CPT as HPI Element	TOTAL	4		
	LEVEL	4		
REVIEW OF SYSTEMS (ROS)				
		Documented		
1. Constitutional (e.g., weight loss, fever)		X		
2. Ophthalmologic (eyes)		X		
3. Otolaryngologic (ears, nose, mouth, throat)		X		
4. Cardiovascular		X		
5. Respiratory		X		
6. Gastrointestinal		X		
7. Genitourinary		X		
8. Musculoskeletal		X		
9. Integumentary (skin and/or breasts)		X		
10. Neurologic		X		
11. Psychiatric				
12. Endocrine				
13. Hematologic/Lymphatic				
14. Allergic/Immunologic				
	TOTAL	10		
	LEVEL	4		
PAST, FAMILY, AND/OR SOCIAL HISTORY (PFSH)				
		Documented		
1. Past illness, operations, injuries, treatments, and current medications		X		
2. Family medical history for heredity and risk		X		
3. Social activities, both past and present		X		
	TOTAL	3		
	LEVEL	4		
History Level	1	2	3	4
	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
HPI	Brief 1-3	Brief 1-3	Extended 4+	Extended 4+
ROS	None	Problem Pertinent	Extended 2-9	Complete 10+
PFSH	None	None	Pertinent 1	Complete 2-3
HISTORY LEVEL				4

EXAMINATION ELEMENTS			Documented	
<b>CONSTITUTIONAL (OS)</b>				
• Blood pressure, sitting			X	
• Blood pressure, lying				
• Pulse			X	
• Respirations			X	
• Temperature				
• Height				
• Weight				
• General appearance			X	
(Counts as only 1) NUMBER			1	
<b>BODY AREAS (BA)</b>			Documented	
1. Head (including face)				
2. Neck				
3. Chest (including breasts and axillae)				
4. Abdomen			X	
5. Genitalia, groin, buttocks				
6. Back (including spine)				
7. Each extremity				
NUMBER			1	
<b>ORGAN SYSTEMS (OS)</b>			Documented	
1. Ophthalmologic (eyes)				
2. Otolaryngologic (ears, nose, mouth, throat)				
3. Cardiovascular			X	
4. Respiratory			X	
5. Gastrointestinal			X	
6. Genitourinary			X	
7. Musculoskeletal				
8. Integumentary (skin)				
9. Neurologic				
10. Psychiatric				
11. Hematologic/Lymphatic/Immunologic				
NUMBER			4	
TOTAL BA/OS			6/4	
Exam Level	1	2	3	4
	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
	Limited to affected BA/OS	Limited to affected BA/OS & other related OS(s)	Extended of affected BA(s) & other related OS(s)	General multi-system (OSs only)
# of OS or BA	1	2-7 limited	2-7 extended	8+
EXAMINATION LEVEL				3

MDM ELEMENTS				Documented
# OF DIAGNOSIS/MANAGEMENT OPTIONS				
1. Minimal				
2. Limited				
3. Multiple				
4. Extensive				X
LEVEL				
AMOUNT OR COMPLEXITY OF DATA TO REVIEW				Documented
1. Minimal/None				
2. Limited				X
3. Moderate				
4. Extensive				
LEVEL				
RISK OF COMPLICATION OR DEATH IF NOT TREATED				Documented
1. Minimal				
2. Low				
3. Moderate				
4. High				X
LEVEL				4
MDM*	1	2	3	4
	Straightforward	Low	Moderate	High
Number of DX or management options	Minimal	Limited	Multiple	Extensive
Amount and/or complexity of data	Minimal/None	Limited	Moderate	Extensive
Risks	Minimal	Low	Moderate	High
			MDM LEVEL	4
*To qualify for a given type of MDM complexity, 2 of 3 elements in the table must be met or exceeded.				

History: Comprehensive  
 Examination: Detailed  
 MDM: High  
 Number of Key Components: 3 of 3  
 99221

**AUDIT REPORT 1.2 CONSULTATION****Incorrect code: 99254**

**RATIONALE:** This is an inpatient consult. The HPI contains 4 elements: location (right tibia/fibula), context (slipped on ice and fell), severity (pain 5/10), and modifying factor (worse with movement). The HPI is comprehensive. The ROS is detailed. The report states that a full review of systems was performed and lists the systems; however, rheumatology and oncology are not systems; therefore, this cannot be counted as a comprehensive ROS. The PFSH includes past (hernia repair), family (father died of stroke at 39), and social (smokes) for a comprehensive PFSH. This is a detailed history.

The examination is comprehensive as nine systems were examined: constitutional (pulse, respiration, blood pressure), ophthalmologic (pupils are reactive), otolaryngologic (oral mucosa is slightly dry), cardiovascular (S1 and S2 regular, no clubbing, edema), respiratory (clear to auscultation), gastrointestinal (soft, bowel sounds, nontender), neurologic (grossly normal), psychiatric (normal mood, alert and oriented  $\times$  3), and integumentary (no acute rashes).

The number of diagnoses/treatment options is comprehensive (fracture, abnormal EKG, hypertension, hyperlipidemia). The amount and/or complexity of data is limited (EKG, labs) and the risk is high (unscheduled surgery). The MDM is high complexity. Inpatient Consultation codes require all 3 key components meet or exceed the stated requirements.

Consultation was requested to evaluate the patient for a preoperative cardiovascular examination, not as an evaluation for the fracture.

The Volume 1 ICD-10-CM coding convention for Z01.810, Encounter for preprocedural cardiovascular examination, directs listing this code first. Although no specific guideline is provided in the Section 1 guidelines for an inpatient encounter, in addition to the Tabular symbol preceding Z01.810, guidelines are provided as a coding template in Section IV, Diagnostic Coding and Reporting Guidelines, IV.M., Patients receiving preoperative evaluations only, which states to sequence a code from subcategory Z01.81, next assign a code to describe the condition requiring surgery, and then code any findings related to the pre-operative examination.

ICD-10-CM DX: Z01.810; Preprocedural cardiovascular examination; S82.201A, Traumatic tibia fracture; S82.401A, Traumatic fibular fracture; 110, Hypertension; E78.5, Hyperlipidemia; R94.31, Abnormal electrocardiogram.

The detailed history, comprehensive examination, and high complexity MDM make this consultation 99253.

CHAPTER 1, AUDIT REPORT 1.2

HISTORY ELEMENTS		Documented		
HISTORY OF PRESENT ILLNESS (HPI)				
1. Location (site on body)		X		
2. Quality (characteristic: throbbing, sharp)				
3. Severity (1/10 or how intense)		X		
4. Duration* (how long for problem or episode)				
5. Timing (when it occurs)				
6. Context (under what circumstances does it occur)		X		
7. Modifying factors (what makes it better or worse)		X		
8. Associated signs and symptoms (what else is happening when it occurs)				
*Duration not in CPT as HPI Element	TOTAL	4		
	LEVEL	4		
REVIEW OF SYSTEMS (ROS)				
1. Constitutional (e.g., weight loss, fever)				
2. Ophthalmologic (eyes)				
3. Otolaryngologic (ears, nose, mouth, throat)				
4. Cardiovascular		X		
5. Respiratory		X		
6. Gastrointestinal		X		
7. Genitourinary				
8. Musculoskeletal		X		
9. Integumentary (skin and/or breasts)				
10. Neurologic		X		
11. Psychiatric				
12. Endocrine		X		
13. Hematologic/Lymphatic				
14. Allergic/Immunologic		X		
	TOTAL	7		
	LEVEL	3		
PAST, FAMILY, AND/OR SOCIAL HISTORY (PFSH)				
1. Past illness, operations, injuries, treatments, and current medications		X		
2. Family medical history for heredity and risk		X		
3. Social activities, both past and present		X		
	TOTAL	3		
	LEVEL	4		
History Level	1	2	3	4
	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
HPI	Brief 1-3	Brief 1-3	Extended 4+	Extended 4+
ROS	None	Problem Pertinent	Extended 2-9	Complete 10+
PFSH	None	None	Pertinent 1	Complete 2-3
HISTORY LEVEL				3

EXAMINATION ELEMENTS		Documented		
CONSTITUTIONAL (OS)				
• Blood pressure, sitting		X		
• Blood pressure, lying				
• Pulse		X		
• Respirations		X		
• Temperature				
• Height				
• Weight				
• General appearance				
(Counts as only 1) NUMBER		1		
BODY AREAS (BA)		Documented		
1. Head (including face)		X		
2. Neck		X		
3. Chest (including breasts and axillae)				
4. Abdomen				
5. Genitalia, groin, buttocks				
6. Back (including spine)				
7. Each extremity		X		
NUMBER		3		
ORGAN SYSTEMS (OS)		Documented		
1. Ophthalmologic (eyes)		X		
2. Otolaryngologic (ears, nose, mouth, throat)		X		
3. Cardiovascular		X		
4. Respiratory		X		
5. Gastrointestinal		X		
6. Genitourinary				
7. Musculoskeletal				
8. Integumentary (skin)		X		
9. Neurologic		X		
10. Psychiatric		X		
11. Hematologic/Lymphatic/Immunologic				
NUMBER		8		
TOTAL BA/OS		12/9		
Exam Level	1	2	3	4
	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
	Limited to affected BA/OS	Limited to affected BA/OS & other related OS(s)	Extended of affected BA(s) & other related OS(s)	General multi-system (OSs only)
# of OS or BA	1	2-7 limited	2-7 extended	8+
EXAMINATION LEVEL				4

MDM ELEMENTS		Documented		
# OF DIAGNOSIS/MANAGEMENT OPTIONS				
1. Minimal				
2. Limited				
3. Multiple				
4. Extensive		X		
LEVEL				
AMOUNT OR COMPLEXITY OF DATA TO REVIEW		Documented		
1. Minimal/None				
2. Limited		X		
3. Moderate				
4. Extensive				
LEVEL				
RISK OF COMPLICATION OR DEATH IF NOT TREATED		Documented		
1. Minimal				
2. Low				
3. Moderate		X		
4. High				
LEVEL		4		
MDM*	1	2	3	4
	Straightforward	Low	Moderate	High
Number of DX or management options	Minimal	Limited	Multiple	Extensive
Amount and/or complexity of data	Minimal/None	Limited	Moderate	Extensive
Risks	Minimal	Low	Moderate	High
			MDM LEVEL	3
*To qualify for a given type of MDM complexity, 2 of 3 elements in the table must be met or exceeded.				

History: Detailed  
 Examination: Comprehensive  
 MDM: Moderate  
 Number of Key Components: 3 of 3  
 99253

## AUDIT REPORT 1.3 NEUROLOGY CONSULTATION

### Incorrect code: 99243

**RATIONALE:** There are 4 HPI elements: location (head), duration (1 to 2 nights ago), timing (once every 3 months and last night), and modifying factor (worse if she looked over to the right interior vision) for a level 4 or comprehensive HPI. There were 10 ROS: constitutional (denies fever or chills), ophthalmologic (double vision), gastrointestinal (denies nausea or vomiting), otolaryngologic (some sinus congestion), and all other systems are negative. All 3 of the PFSH were noted: past (medications), family (mother has migraines), and social (smokes) for a level 4 or comprehensive PFSH. This is a level 4 or comprehensive history.

The examination included 4 constitutional elements (temperature, respiration, pulse, and blood pressure, and she appears comfortable) for 1 OS. There was 1 BA of head (atraumatic). There were 7 OSs: ophthalmologic (no photophobia or meningismus), respiratory (clear to auscultation), cardiovascular (regular rate and rhythm), gastrointestinal (abdomen soft, nontender), integumentary (skin warm and dry), neurologic (oriented  $\times$  3), and psychiatric (she becomes somewhat anxious). There was a total of 9 BAs/OSs. At least 8 OSs must be examined to qualify as a comprehensive examination. There are 8 OSs for a level 4 or comprehensive examination.

The MDM contained multiple diagnoses/management options (headache, double vision, anxiety), minimal data to review (none), and moderate risk (prescribed drug management). This is a level 3 or moderate MDM.

The comprehensive history, comprehensive examination and moderate MDM support 99244.



CHAPTER 1, AUDIT REPORT 1.3

HISTORY ELEMENTS		Documented		
HISTORY OF PRESENT ILLNESS (HPI)				
1. Location (site on body)		X		
2. Quality (characteristic: throbbing, sharp)				
3. Severity (1/10 or how intense)		X		
4. Duration* (how long for problem or episode)		X		
5. Timing (when it occurs)				
6. Context (under what circumstances does it occur)				
7. Modifying factors (what makes it better or worse)		X		
8. Associated signs and symptoms (what else is happening when it occurs)				
*Duration not in CPT as HPI Element	TOTAL	4		
	LEVEL	4		
REVIEW OF SYSTEMS (ROS)				
		Documented		
1. Constitutional (e.g., weight loss, fever)		X		
2. Ophthalmologic (eyes)		X		
3. Otolaryngologic (ears, nose, mouth, throat)		X		
4. Cardiovascular		X		
5. Respiratory		X		
6. Gastrointestinal		X		
7. Genitourinary		X		
8. Musculoskeletal		X		
9. Integumentary (skin and/or breasts)		X		
10. Neurologic		X		
11. Psychiatric		X		
12. Endocrine		X		
13. Hematologic/Lymphatic		X		
14. Allergic/Immunologic		X		
	TOTAL	14		
	LEVEL	4		
PAST, FAMILY, AND/OR SOCIAL HISTORY (PFSH)				
		Documented		
1. Past illness, operations, injuries, treatments, and current medications		X		
2. Family medical history for heredity and risk		X		
3. Social activities, both past and present		X		
	TOTAL	3		
	LEVEL	4		
History Level	1	2	3	4
	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
HPI	Brief 1-3	Brief 1-3	Extended 4+	Extended 4+
ROS	None	Problem Pertinent	Extended 2-9	Complete 10+
PFSH	None	None	Pertinent 1	Complete 2-3
	HISTORY LEVEL			4

EXAMINATION ELEMENTS		Documented		
CONSTITUTIONAL (OS)				
• Blood pressure, sitting		X		
• Blood pressure, lying				
• Pulse		X		
• Respirations		X		
• Temperature		X		
• Height				
• Weight		X		
• General appearance				
(Counts as only 1) NUMBER		1		
BODY AREAS (BA)		Documented		
1. Head (including face)		X		
2. Neck				
3. Chest (including breasts and axillae)				
4. Abdomen				
5. Genitalia, groin, buttocks				
6. Back (including spine)				
7. Each extremity				
NUMBER		1		
ORGAN SYSTEMS (OS)		Documented		
1. Ophthalmologic (eyes)		X		
2. Otolaryngologic (ears, nose, mouth, throat)				
3. Cardiovascular		X		
4. Respiratory		X		
5. Gastrointestinal		X		
6. Genitourinary				
7. Musculoskeletal				
8. Integumentary (skin)		X		
9. Neurologic				
10. Psychiatric		X		
11. Hematologic/Lymphatic/Immunologic		X		
NUMBER		7		
TOTAL BA/OS		9/8		
Exam Level	1	2	3	4
	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
	Limited to affected BA/OS	Limited to affected BA/OS & other related OS(s)	Extended of affected BA(s) & other related OS(s)	General multi-system (OSs only)
# of OS or BA	1	2-7 limited	2-7 extended	8+
EXAMINATION LEVEL				4

MDM ELEMENTS				Documented
# OF DIAGNOSIS/MANAGEMENT OPTIONS				
1. Minimal				
2. Limited				
3. Multiple				X
4. Extensive				
LEVEL				3
AMOUNT OR COMPLEXITY OF DATA TO REVIEW				
1. Minimal/None				X
2. Limited				
3. Moderate				
4. Extensive				
LEVEL				1
RISK OF COMPLICATION OR DEATH IF NOT TREATED				
1. Minimal				
2. Low				
3. Moderate				X
4. High				
LEVEL				3
MDM*	1	2	3	4
	Straightforward	Low	Moderate	High
Number of DX or management options	Minimal	Limited	Multiple	Extensive
Amount and/or complexity of data	Minimal/None	Limited	Moderate	Extensive
Risks	Minimal	Low	Moderate	High
			MDM LEVEL	3
*To qualify for a given type of MDM complexity, 2 of 3 elements in the table must be met or exceeded.				

History: Comprehensive  
 Examination: Comprehensive  
 MDM: Moderate  
 Number of Key Components: 3 of 3  
 99244

**AUDIT REPORT 1.4 EMERGENCY DEPARTMENT SERVICES****Incorrect code: 99282**

**RATIONALE:** The HPI included 3 elements: location (ankle), context (cow stomped her), and associated signs and symptoms (abrasions) for a level 2 or expanded problem focused HPI. The ROS included 4 elements: musculoskeletal (no neck, back, chest, abdomen, or pelvic pain), integumentary (complaining of abrasions on leg and chin), neurologic (denies loss of consciousness or headache), and psychiatric (stoic) for a level 3 or detailed ROS. All three elements of the PFSH were noted for a level 4 or comprehensive PFSH. An expanded problem focused HPI (level 2), detailed ROS (level 3), and comprehensive PFSH (level 4) place this history service at a level 2 or expanded problem focused.

The examination included no constitutional elements, so this will not count for any organ systems. There were 4 body areas: head (normocephalic), neck (trachea), chest (nontender), and abdomen (soft). There were 7 organ systems: ophthalmologic (pupils), otolaryngologic (hemotympanum), cardiovascular (pulses), respiratory (lungs clear), integumentary (abrasions), musculoskeletal (long bones-dislocation), and neurologic (oriented  $\times$  3). The total number of BAs/OSs is 11, which would usually be a level 4 or comprehensive examination. However, for a comprehensive examination the BAs are not counted. With a total of 7 OSs, this examination is a level 3 or detailed physical examination.

The MDM contained multiple diagnoses/management options (open ankle dislocation, multiple abrasions, reduction of the dislocation, examination of the spine and chest due to the mechanism of the injury [stomped by cow]), moderate data were reviewed (x-ray spine, chest, and pre- and post-reduction films), and a moderate risk to the patient for mortality or morbidity if gone untreated (toes are dusky) for a level 3 or moderate MDM.

All 3 key components are required. An expanded problem focused history, detailed examination, and medical decision making of moderate complexity would be reported with 99283.

**Missing codes: W55.89XA, Y93.K9**

The diagnoses are listed in the Assessment, which are the open dislocation of the ankle and the abrasion of the chin and leg. An external cause code is assigned to indicate how this injury occurred—stepped on by an animal (W55.89XA). When there is an activity, it is also reported. In this case, animal care (Y93.K9). The ICD-10-CM 7th character “A” reports the initial encounter. The tetanus vaccination would be included in the diagnosis for the facility services only.

## CHAPTER 1, AUDIT REPORT 1.4

HISTORY ELEMENTS		Documented		
HISTORY OF PRESENT ILLNESS (HPI)				
1. Location (site on body)		X		
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)		X		
7. Modifying factors (what makes it better or worse)				
8. Associated signs and symptoms (what else is happening when it occurs)		X		
*Duration not in CPT as HPI Element	TOTAL	3		
	LEVEL	2		
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. Gastrointestinal				
7. Genitourinary				
8. Musculoskeletal		X		
9. Integumentary (skin and/or breasts)		X		
10. Neurological		X		
11. Psychiatric		X		
12. Endocrine				
13. Hematologic/Lymphatic				
14. Allergic/Immunologic				
	TOTAL	4		
	LEVEL	3		
PAST, FAMILY, AND/OR SOCIAL HISTORY (PFSH)				
Documented				
1. Past illness, operations, injuries, treatments, and current medications		X		
2. Family medical history for heredity and risk		X		
3. Social activities, both past and present		X		
	TOTAL	3		
	LEVEL	4		
History Level	1	2	3	4
	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
HPI	Brief 1-3	Brief 1-3	Extended 4+	Extended 4+
ROS	None	Problem Pertinent 1	Extended 2-9	Complete 10+
PFSH	None	None	Pertinent 1	Complete 2-3
HISTORY LEVEL				2

EXAMINATION ELEMENTS		Documented		
<b>CONSTITUTIONAL (OS)</b>				
• Blood pressure, sitting				
• Blood pressure, lying				
• Pulse				
• Respirations				
• Temperature				
• Height				
• Weight				
• General appearance				
(Counts as only 1) <b>NUMBER</b>		<b>0</b>		
<b>BODY AREAS (BA)</b>		<b>Documented</b>		
1. Head (including face)		<b>X</b>		
2. Neck		<b>X</b>		
3. Chest (including breasts and axillae)		<b>X</b>		
4. Abdomen		<b>X</b>		
5. Genitalia, groin, buttocks				
6. Back (including spine)				
7. Each extremity				
<b>NUMBER</b>		<b>4</b>		
<b>ORGAN SYSTEMS (OS)</b>		<b>Documented</b>		
1. Ophthalmologic (eyes)		<b>X</b>		
2. Otolaryngologic (ears, nose, mouth, throat)		<b>X</b>		
3. Cardiovascular		<b>X</b>		
4. Respiratory		<b>X</b>		
5. Gastrointestinal				
6. Genitourinary				
7. Musculoskeletal		<b>X</b>		
8. Integumentary (skin)		<b>X</b>		
9. Neurologic		<b>X</b>		
10. Psychiatric				
11. Hematologic/Lymphatic/Immunologic				
<b>NUMBER</b>		<b>7</b>		
<b>TOTAL BA/OS</b>		<b>11(7)</b>		
<b>Exam Level</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
	<b>Problem Focused</b>	<b>Expanded Problem Focused</b>	<b>Detailed</b>	<b>Comprehensive</b>
	Limited to affected BA/OS	Limited to affected BA/OS & other related OS(s)	Extended of affected BA(s) & other related OS(s)	General multi-system (OSs only)
<b># of OS or BA</b>	<b>1</b>	<b>2-7 limited</b>	<b>2-7 extended</b>	<b>8+</b>
<b>EXAMINATION LEVEL</b>				<b>3</b>

MDM ELEMENTS		Documented		
# OF DIAGNOSIS/MANAGEMENT OPTIONS				
1. Minimal				
2. Limited				
3. Multiple		X		
4. Extensive				
LEVEL		3		
AMOUNT AND/OR COMPLEXITY OF DATA TO REVIEW				
		Documented		
1. Minimal/None				
2. Limited				
3. Moderate		X		
4. Extensive				
LEVEL		3		
RISK OF COMPLICATION OR DEATH IF NOT TREATED				
		Documented		
1. Minimal				
2. Low				
3. Moderate		X		
4. High				
LEVEL		3		
MDM*	1	2	3	4
	Straightforward	Low	Moderate	High
Number of DX or management options	Minimal	Limited	Multiple	Extensive
Amount and/or complexity of data	Minimal/None	Limited	Moderate	Extensive
Risks	Minimal	Low	Moderate	High
			MDM LEVEL	3
*To qualify for a given type of MDM complexity, 2 of 3 elements in the table must be met or exceeded.				

History: Expanded Problem Focused  
 Examination: Detailed  
 MDM: Moderate  
 Number of Key Components: 3 of 3  
 Code: 99283

## AUDIT REPORT 1.5 PROGRESS NOTE SERVICES

### Incorrect code: 99232

**RATIONALE:** Subsequent hospital care includes the review of the medical record and any diagnostic studies that have been done since the last visit. The physician gathers information about any changes in the patient's status from the documentation in the medical record and from the patient. The HPI included 4 elements: severity (pain better), modifying factors (better after epidural pump), and associated signs and symptoms (increased secretions), quality (rattling) for a level 4 or comprehensive HPI. The ROS included 3 elements: constitutional (fever), respiratory (not coughing up mucous or secretions), musculoskeletal (pain) for a level 3 or detailed ROS. There were no elements of the PFSH noted. The PFSH is not required to be updated during the subsequent hospital visit. Comprehensive HPI (level 4), detailed ROS (level 3), and no PFSH for detailed history (level 3).

The examination included three constitutional elements (blood pressure, temperature, and general appearance), this will count for one organ system. There were 2 body areas: neck (supple) and abdomen (benign). There were 4 organ systems: otolaryngologic (ENT of HEENT), cardiovascular (pulses), respiratory (clear), and psychiatric (no acute distress). The total number of BAs/OSs is 7 for a level 3 or detailed examination.

The MDM is low, as it contained limited diagnosis/management options (multiple pain areas). Limited data were reviewed (blood and Gram stain) and a low risk to the patient for a level 2 or low MDM.

### Missing code: F17.210

The diagnoses are listed as they appear in the Assessment, which are the pleuritic chest pain, low back pain, lung cancer, and the patient's COPD. The patient uses tobacco, which is reported as tobacco abuse with F17.210. There are other diagnoses listed in the assessment section of the report of malnutrition, hepatitis C, depression, hypertension, pains; but these conditions are not being managed or documented as affecting the care so these conditions are not coded.

## CHAPTER 1, AUDIT REPORT 1.5

HISTORY ELEMENTS		Documented		
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	TOTAL	4		
	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		✗		
6. Gastrointestinal				
7. Genitourinary				
8. Musculoskeletal		✗		
9. Integumentary (skin and/or breasts)				
10. Neurological				
11. Psychiatric				
12. Endocrine				
13. Hematologic/Lymphatic				
14. Allergic/Immunologic				
	TOTAL	3		
	LEVEL	3		
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				
	TOTAL	0		
	LEVEL	2		
History Level	1	2	3	4
	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
HPI	Brief 1-3	Brief 1-3	Extended 4+	Extended 4+
ROS	None	Problem Pertinent 1	Extended 2-9	Complete 10+
PFSH	None	None	Pertinent 1	Complete 2-3
HISTORY LEVEL				3

EXAMINATION ELEMENTS		Documented		
CONSTITUTIONAL (OS)				
• Blood pressure, sitting				
• Blood pressure, lying		X		
• Pulse				
• Respirations				
• Temperature		X		
• Height				
• Weight				
• General appearance		X		
(Counts as only 1) NUMBER		1		
BODY AREAS (BA)		Documented		
1. Head (including face)				
2. Neck		X		
3. Chest (including breasts and axillae)				
4. Abdomen		X		
5. Genitalia, groin, buttocks				
6. Back (including spine)				
7. Each extremity				
NUMBER		2		
ORGAN SYSTEMS (OS)		Documented		
1. Ophthalmologic (eyes)				
2. Otolaryngologic (ears, nose, mouth, throat)		X		
3. Cardiovascular		X		
4. Respiratory		X		
5. Gastrointestinal				
6. Genitourinary				
7. Musculoskeletal				
8. Integumentary (skin)				
9. Neurologic				
10. Psychiatric		X		
11. Hematologic/Lymphatic/Immunologic				
NUMBER		4		
TOTAL BA/OS		7		
Exam Level	1	2	3	4
	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
	Limited to affected BA/OS	Limited to affected BA/OS & other related OS(s)	Extended of affected BA(s) & other related OS(s)	General multi-system (OSs only)
# of OS or BA	1	2-7 limited	2-7 extended	8+
EXAMINATION LEVEL				3

MDM ELEMENTS		Documented		
# OF DIAGNOSIS/MANAGEMENT OPTIONS				
1. Minimal				
2. Limited		X		
3. Multiple				
4. Extensive				
	LEVEL	2		
AMOUNT AND/OR COMPLEXITY OF DATA TO REVIEW				
1. Minimal/None				
2. Limited		X		
3. Moderate				
4. Extensive				
	LEVEL	2		
RISK OF COMPLICATION OR DEATH IF NOT TREATED				
1. Minimal				
2. Low		X		
3. Moderate				
4. High				
	LEVEL	2		
MDM*	1	2	3	4
	Straightforward	Low	Moderate	High
Number of DX or management options	Minimal	Limited	Multiple	Extensive
Amount and/or complexity of data	Minimal/None	Limited	Moderate	Extensive
Risks	Minimal	Low	Moderate	High
			MDM LEVEL	2
*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: Low

Number of Key Components: 2 of 3

Code: 99233

## AUDIT REPORT 1.6 CONSULTATION

**Incorrect code: 99255**

**Missing codes: 99356, 99357**

**RATIONALE:** The HPI included 3 elements: location (GI), duration (2 days), and associated signs and symptoms (black emesis and tarry stool) for a level 2 or expanded problem focused HPI. The ROS included 5 elements: constitutional (fever), cardiovascular (chest pain), respiratory (dyspnea), gastrointestinal (change bowel habits), genitourinary (voiding) for a level 3 or detailed ROS. All three elements of the PFSH were noted for a level 4 or comprehensive PFSH. An expanded problem focused HPI (level 2), detailed ROS (level 3), and comprehensive PFSH (level 4) place this history service at a level 2 or expanded problem focused.

The examination included three constitutional elements (blood pressure, pulse, and respiration), so this will count for one organ system. There were 2 body areas: neck (supple) and abdomen (soft). There were 7 organ systems: ophthalmologic (sclerae), otolaryngologic (nasal or ear discharge), cardiovascular (regular rate and rhythm and equal pulses), respiratory (wheezes), gastrointestinal (tender to deep palpation), psychiatric (no acute distress), and lymphatic (lymphadenopathy). The total number of BAs/OSs is 10, which would ordinarily qualify as a level 4 or comprehensive examination; however, BAs do not count when assigning a level 4 examination. Recounting using only OSs, you would have 1 constitutional element (which counts as 1 OS) and 7 OSs, for a total of 8 OSs, which is still a comprehensive level examination.

The MDM contained limited diagnosis/management options (diabetic ketoacidosis and GI bleeding), moderate data were reviewed (lab and review of multiple medications the patient is on), and a moderate risk to the patient for a level 3 or moderate MDM.

This level of consultation is a 99252, but as it states at the end of the note, this physician spent 2 hours and 20 minutes with this patient. It doesn't qualify for critical care services because the patient was not critically ill, but you can bill for prolonged services. According to your CPT book, a 99252 typically takes 40 minutes. So you would have 100 extra minutes for which you could bill prolonged services. Code 99356 is for unit time up to 1 hour of prolonged care, and code 99357 is for each additional 30 minutes. In this case you have the 100 minutes, so code both 99356 and 99357.

**Incorrect code: E10.65**

**Missing codes: K92.2, I10**

Reported diagnoses include gastrointestinal bleeding and hypertension, as they impact the diabetes ketoacidosis.

CHAPTER 1, AUDIT REPORT 1.6

HISTORY ELEMENTS			Documented	
HISTORY OF PRESENT ILLNESS (HPI)				
1. Location (site on body)			X	
2. Quality (characteristic: throbbing, sharp)				
3. Severity (1/10 or how intense)				
4. Duration* (how long for problem or episode)			X	
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)			X	
*Duration not in CPT as HPI Element	TOTAL		3	
	LEVEL		2	
REVIEW OF SYSTEMS (ROS)				
1. Constitutional (e.g., weight loss, fever)			X	
2. Ophthalmologic (eyes)				
3. Otolaryngologic (ears, nose, mouth, throat)				
4. Cardiovascular			X	
5. Respiratory			X	
6. Gastrointestinal			X	
7. Genitourinary			X	
8. Musculoskeletal				
9. Integumentary (skin and/or breasts)				
10. Neurological				
11. Psychiatric				
12. Endocrine				
13. Hematologic/Lymphatic				
14. Allergic/Immunologic				
	TOTAL		5	
	LEVEL		3	
PAST, FAMILY, AND/OR SOCIAL HISTORY (PFSH)				
1. Past illness, operations, injuries, treatments, and current medications			X	
2. Family medical history for heredity and risk			X	
3. Social activities, both past and present			X	
	TOTAL		3	
	LEVEL		4	
History Level	1	2	3	4
	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
HPI	Brief 1-3	Brief 1-3	Extended 4+	Extended 4+
ROS	None	Problem Pertinent 1	Extended 2-9	Complete 10+
PFSH	None	None	Pertinent 1	Complete 2-3
HISTORY LEVEL				2

EXAMINATION ELEMENTS		Documented		
CONSTITUTIONAL (OS)				
• Blood pressure, sitting				
• Blood pressure, lying		X		
• Pulse		X		
• Respirations		X		
• Temperature				
• Height				
• Weight				
• General appearance				
(Counts as only 1) NUMBER		1		
BODY AREAS (BA)				
		Documented		
1. Head (including face)				
2. Neck		X		
3. Chest (including breasts and axillae)				
4. Abdomen		X		
5. Genitalia, groin, buttocks				
6. Back (including spine)				
7. Each extremity				
NUMBER		2		
ORGAN SYSTEMS (OS)				
		Documented		
1. Ophthalmologic (eyes)		X		
2. Otolaryngologic (ears, nose, mouth, throat)		X		
3. Cardiovascular		X		
4. Respiratory		X		
5. Gastrointestinal		X		
6. Genitourinary				
7. Musculoskeletal				
8. Integumentary (skin)				
9. Neurologic				
10. Psychiatric		X		
11. Hematologic/Lymphatic/Immunologic		X		
NUMBER		7		
TOTAL BA/OS		10(8)		
Exam Level	1	2	3	4
	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
	Limited to affected BA/OS	Limited to affected BA/OS & other related OS(s)	Extended of affected BA(s) & other related OS(s)	General multi-system (OSs only)
# of OS or BA	1	2-7 limited	2-7 extended	8+
EXAMINATION LEVEL				4

MDM ELEMENTS		Documented		
# OF DIAGNOSIS/MANAGEMENT OPTIONS				
1. Minimal				
2. Limited		X		
3. Multiple				
4. Extensive				
	LEVEL	2		
AMOUNT AND/OR COMPLEXITY OF DATA TO REVIEW				
1. Minimal/None				
2. Limited				
3. Moderate		X		
4. Extensive				
	LEVEL	3		
RISK OF COMPLICATION OR DEATH IF NOT TREATED				
1. Minimal				
2. Low				
3. Moderate		X		
4. High				
	LEVEL	3		
MDM*	1	2	3	4
	Straightforward	Low	Moderate	High
Number of DX or management options	Minimal	Limited	Multiple	Extensive
Amount and/or complexity of data	Minimal/None	Limited	Moderate	Extensive
Risks	Minimal	Low	Moderate	High
			MDM LEVEL	3
*To qualify for a given type of MDM complexity, 2 of 3 elements in the table must be met or exceeded.				

History: Expanded Problem Focused  
 Examination: Comprehensive  
 MDM: Moderate  
 Number of Key Components: 3 of 3  
 Code: 99252