

Established Patient – General Multisystem Exam
(Two of the Three KEY components are required – History, Exam, Medical Decision Making)

	99211	99212	99213	99214	99215
	Minimal	Problem Focused	Exp Problem Focused	Detailed	Comprehensive
H P I		At Least 1: <input type="checkbox"/> Location <input type="checkbox"/> Quality <input type="checkbox"/> Severity <input type="checkbox"/> Duration <input type="checkbox"/> Timing <input type="checkbox"/> Context <input type="checkbox"/> Modifying factors <input type="checkbox"/> Assoc signs/ symptoms	At Least 1 <input type="checkbox"/> Location <input type="checkbox"/> Quality <input type="checkbox"/> Severity <input type="checkbox"/> Duration <input type="checkbox"/> Timing <input type="checkbox"/> Context <input type="checkbox"/> Modifying factors <input type="checkbox"/> Assoc signs/ symptoms	At Least 4: or At Least 3: <input type="checkbox"/> Location Chr Dx <input type="checkbox"/> Quality Chr Dx <input type="checkbox"/> Severity Chr Dx <input type="checkbox"/> Duration <input type="checkbox"/> Timing <input type="checkbox"/> Context <input type="checkbox"/> Modifying factors <input type="checkbox"/> Assoc signs/symptom	At Least 4: or At Least 3: <input type="checkbox"/> Location Chr Dx <input type="checkbox"/> Quality Chr Dx <input type="checkbox"/> Severity Chr Dx <input type="checkbox"/> Duration <input type="checkbox"/> Timing <input type="checkbox"/> Context <input type="checkbox"/> Modifying factors <input type="checkbox"/> Assoc signs/symptom
R O S	No ROS	No ROS	At least 1 required <input type="checkbox"/> Constitutional <input type="checkbox"/> Eyes <input type="checkbox"/> ENT/mouth <input type="checkbox"/> CV <input type="checkbox"/> Respiratory <input type="checkbox"/> GI <input type="checkbox"/> GU <input type="checkbox"/> Musculoskeletal <input type="checkbox"/> Skin/Breast <input type="checkbox"/> Neuro <input type="checkbox"/> Psych <input type="checkbox"/> Endocrine <input type="checkbox"/> Hem/lymph <input type="checkbox"/> Allergy/Immuno	At least 2 required <input type="checkbox"/> Constitutional <input type="checkbox"/> Eyes <input type="checkbox"/> ENT/mouth <input type="checkbox"/> CV <input type="checkbox"/> Respiratory <input type="checkbox"/> GI <input type="checkbox"/> GU <input type="checkbox"/> Musculoskeletal <input type="checkbox"/> Skin/Breast <input type="checkbox"/> Neuro <input type="checkbox"/> Psych <input type="checkbox"/> Endocrine <input type="checkbox"/> Hem/lymph <input type="checkbox"/> Allergy/Immuno <input type="checkbox"/> All Others Negative	At least 10 required <input type="checkbox"/> Constitutional <input type="checkbox"/> Eyes <input type="checkbox"/> ENT/mouth <input type="checkbox"/> CV <input type="checkbox"/> Respiratory <input type="checkbox"/> GI <input type="checkbox"/> GU <input type="checkbox"/> Musculoskeletal <input type="checkbox"/> Skin/Breast <input type="checkbox"/> Neuro <input type="checkbox"/> Psych <input type="checkbox"/> Endocrine <input type="checkbox"/> Hem/lymph <input type="checkbox"/> Allergy/Immuno <input type="checkbox"/> All Others Negative
P F S H	No PFSH	NoPFSH	No PFSH	At Least 1 <input type="checkbox"/> Past medical <input type="checkbox"/> Family History <input type="checkbox"/> Social History	At Least 2 <input type="checkbox"/> Past medical <input type="checkbox"/> Family History <input type="checkbox"/> Social History
Exam		At Least 1 from any system /areas	At Least 6 from at least any system/areas	At Least 12 from at least 2 systems/areas	At Least 18 from at least 9 systems/areas
		<p>Constitutional: <input type="checkbox"/> Any three vital signs <input type="checkbox"/> General appearance of patient</p> <p>Eyes: <input type="checkbox"/> Conjunctivae & lids <input type="checkbox"/> Pupils & Irises <input type="checkbox"/> Optic discs</p> <p>ENT: <input type="checkbox"/> External ears & nose <input type="checkbox"/> EACs & TMs <input type="checkbox"/> Hearing <input type="checkbox"/> Nasal mucosa, septum & turbinates <input type="checkbox"/> Lips, teeth & gums <input type="checkbox"/> Oropharynx</p> <p>Neck: <input type="checkbox"/> Neck <input type="checkbox"/> Thyroid</p> <p>Respiratory: <input type="checkbox"/> Respiratory effort <input type="checkbox"/> Percussion <input type="checkbox"/> Palpation <input type="checkbox"/> Auscultation</p> <p>Cardio/Vascular: <input type="checkbox"/> Palpation of heart <input type="checkbox"/> Auscultation <input type="checkbox"/> Carotids <input type="checkbox"/> Abdominal aorta <input type="checkbox"/> Femoral <input type="checkbox"/> Pedal pulses <input type="checkbox"/> Extremities for edema &/or varicosities</p> <p>Chest: <input type="checkbox"/> Inspection of breasts <input type="checkbox"/> Palpation of breast & axillae</p> <p>GI (Abdomen): <input type="checkbox"/> Masses & tenderness <input type="checkbox"/> Liver & Spleen <input type="checkbox"/> Hernia <input type="checkbox"/> Anus, perineum & rectum <input type="checkbox"/> Occult test</p> <p>GU: MALE: <input type="checkbox"/> Scrotal contents <input type="checkbox"/> Penis <input type="checkbox"/> Prostate gland FEMALE: <input type="checkbox"/> External genitalia <input type="checkbox"/> Urethra <input type="checkbox"/> Bladder <input type="checkbox"/> Cervix <input type="checkbox"/> Uterus <input type="checkbox"/> Adnexa/parametria</p> <p>Lymph: Lymph nodes in two or more areas: <input type="checkbox"/> Neck <input type="checkbox"/> Axillae <input type="checkbox"/> Groin <input type="checkbox"/> Other</p> <p>Muscular: <input type="checkbox"/> Gait & Station <input type="checkbox"/> Digit & nails Joint(s), bone(s), muscles of at least one area: 1) Head, neck 2) spine, ribs, pelvis 3) right upper extremity 4) left upper extremity 5) right lower extremity 6) left lower extremity, including: <input type="checkbox"/> inspection &/or palpation <input type="checkbox"/> ROM <input type="checkbox"/> Stability <input type="checkbox"/> Strength & tone</p> <p>Skin: <input type="checkbox"/> Inspection of skin & subcutaneous tissue <input type="checkbox"/> Palpation of skin & subcutaneous tissue</p> <p>Neuro: <input type="checkbox"/> Cranial nerves <input type="checkbox"/> Reflexes <input type="checkbox"/> Sensation</p> <p>Psychiatric: <input type="checkbox"/> Judgment & insight <input type="checkbox"/> Orientation to time, place & person <input type="checkbox"/> Memory <input type="checkbox"/> Mood & affect</p>			

Medical Decision Making

SECTION A:

DIAGNOSIS/MANGEMENT OPTIONS

Identify each problem mentioned in the evaluation. Identify the number of problems in each of the categories in Column B in the table. (Some categories have maximum values entered.) Total the score in Column D by multiplying the value identified in Column D for total.

CATEGORIES FOR PROBLEMS OR MAJOR NEW SYMPTOMS (Column A)	Column B	Column C	Column D
Self-limited or minor (stable, improved, worsening)	MAX = 2	1	
Established problem (stable or improved)		1	
Established problem (worsening)		2	
New problem, no additional work up planned	MAX = 1	3	
New problem, additional work up planned		4	
		TOTAL	

SECTION B:

AMOUNT/COMPLEXITY OF DATA TO BE REVIEWED

For each category, circle the number in the Points column. Total the points at the bottom of the column.

CATEGORIES OF DATA TO BE REVIEWED	POINTS
Review and/or order of clinical lab tests	1
Review and/or order of test from the radiology section of CPT (includes nuclear medicine)	1
Review and/or order of tests in the medicine section of CPT (e.g., EMG, SSEP, non-invasive vascular studies, pulmonary function studies, psychological testing)	1
Discussion of test results with performing physician	1
Decision to obtain old records and/or history from someone other than patient	1
Review and summarization of old records and/or obtaining history from someone other than patient and/or discussion of case with another health care providers	2
Independent visualization of image, tracing or specimen itself (not simply review of report)	2
TOTAL	

****SEE TABLE OF RISK FOR DETERMINING SECTION C.**

CUMULATION:

Must meet or exceed 2 of the 3 components within Medical Decision Making

TYPE OF DECISION MAKING	A. NUMBER OF DIANGOSES/ MANAGEMENT OPTIONS	B. AMOUNT/COMPLEXITY OF DATA REVIEWED	C. LEVEL OF RISK
STRAIGHTFORWARD	Minimal = 1	Minimal or low = 1	Minimal
LOW COMPLEXITY	Limited = 2	Limited = 2	Low
MODERATE COMPLEXITY	Multiple = 3	Moderate = 3	Moderate
HIGH COMPLEXITY	Extensive = 4	Extensive = 4	High

REPORTING A LEVEL OF SERVICE BASED ON COUNSELING (TIME):

When more than 50% of the face-to-face time with the patient was spent in addressing counseling components, the visit may be coded based on the total face-to-face time if the CHART DOCUMENTATION supports the time. The documentation must list the total time of the encounter and context of counseling.

Counseling components Diagnostic results o Prognosis o Risks and benefits of treatment options o Impressions o Instructions for management o Importance of compliance with chosen treatment options o Risk factor reductions o Patient and family education

Total time of encounter _____.

Date of service _____ Provider _____ Patient # _____

Code originally reported: _____

Code documentation supported: _____

Additional comments:

ESTABLISHED PATIENT LEVEL OF MEDICAL DECISION MAKING	CPT AVERAGE TIME IF COUNSLEING COMPONENT DRIVEN
99211 - Minimal	99211 - 5 minutes (face-to-face)
99212 - Straightforward	99212 - 10 minutes (face-to-face)
99213 - Low Complexity	99213 - 15 minutes (face-to-face)
99214 - Moderate Complexity	99214 - 25 minutes (face-to-face)
99215 - High Complexity	99215 - 40 minutes (face-to-face)