Office/Other Outpatient Services (Established Patients)

### Components Required: 2 of 3

<table>
<thead>
<tr>
<th>Components Required</th>
<th>99211</th>
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<th>99214</th>
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</thead>
<tbody>
<tr>
<td>History &amp; Exam</td>
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<tr>
<td>Problem focused</td>
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<td>Expanded problem focused</td>
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<td>Detailed</td>
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<td>Comprehensive</td>
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<td>Medical Decision Making</td>
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<td>Straightforward</td>
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<td>Moderate</td>
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<td>High</td>
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<td>Presenting Problem (Severity)</td>
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<td>Minimal</td>
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<td>Self-limited or minor</td>
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<td>Low to moderate</td>
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<td>Moderate to high</td>
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<tr>
<td>Typical Time: Face-to-Face</td>
<td>5</td>
<td>10</td>
<td>15</td>
<td>25</td>
<td>40</td>
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</table>

**HPI – History of Present Illness**

A chronological description of the development of the patient’s present illness from the first sign and/or symptom or from the previous encounter to the present. Descriptions of present illness may include:

- Location
- Quality
- Severity
- Timing
- Context
- Modifying factors
- Associated signs/symptoms significantly related to the presenting problem(s)

**Chief Complaint**

The Chief Complaint is a concise statement from the patient describing:

- The symptom
- Problem
- Condition
- Diagnosis
- Physician recommended return, or other factor that is the reason for the encounter

Medicare allows only the medically necessary portion of the visit. Even if a complete note is generated, only the necessary services for the condition of the patient at the time of the visit can be considered in determining the level of an E/M code.

**Detailed History:**

- Chief complaint
- Extended history of present illness
- Extended review of systems
- Pertinent past family/social history DIRECTLY related to the patient’s problems
Review of Systems

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.

For purpose of Review of Systems the following systems are recognized:

- Constitutional (i.e., fever, weight loss)
- Eyes
- Ears, Nose, Mouth Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary (skin and/or breast)
- Neurologic
- Psychiatric
- Endocrine
- Hematologic/Lymphatic
- Allergic/Immunologic

Past, Family, And/or Social History (PFSH)

Consists of a review of the following:

- Past history (the patient’s past experiences with illnesses, operations, injuries and treatments)
- Family history (a review of medical events in the patient’s family, including diseases which may be hereditary or place the patient at risk)
- Social History (an age appropriate review of past and current activities)

Detailed Physical Exam

Includes:

Extended exam of the affected body region or organ system

- Head, including the face
- Neck
- Chest, including breasts and axillae
- Abdomen

Symptomatic/related body systems or organ systems

- Constitutional (i.e, vital signs, general appearance)
- Eyes
- Ears, nose, mouth, and throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Hematologic/lymphatic/immunologic

Medical Decision Making of HIGH complexity involves 2 of the 3 below:

1. Extensive management options for diagnosis or treatment
2. Extensive amount of data to be reviewed
3. High risk of complications and/or morbidity or mortality

Moderate amount of data to be reviewed consist of:

- Lab results
- Diagnostic & imaging results
- Other practitioners’ notes/charts (e.g., PT, OT, consulting physicians)
- Labs or diagnostics that need to be performed

Moderate risk of complications and/or morbidity or mortality:

- Comorbidities associated with the presenting problem
- Risk(s) of diagnostic procedures(s) performed
- Risk(s) associated with possible management options
Additional Information

- Select the code for the service based upon the content of the service
  - Duration of the visit does NOT control the level of the service to be billed unless more than 50% of the face-to-face time (for non-inpatient service) or more than 50% of the floor time (for inpatient service) is spent providing counseling or coordination of care as described in CMS Publication 100-04 (link provided in reference section of this Fact Sheet)
- Practitioner’s choosing to use time as the determining factor:
  - MUST document time in the patient’s medical record.
  - Documentation MUST support in sufficient detail the nature of the counseling
- Code selection based on total time of the face-to-face encounter (floor time), the medical record MUST be documented in sufficient detail to justify the code selection.
- Face-to-face time refers to the time with the physician ONLY. Counseling by other staff is not considered to be part of the face-to-face physician/patient encounter time. Therefore, the time spent by other staff is NOT considered in selecting the appropriate level of service
- Comorbidities and other underlying diseases in and of themselves are not considered when selecting the E/M codes UNLESS their presence significantly increases the complexity of the medical decision making

References

- American Medical Association CPT (current procedural terminology) Codebook