Example 1. In an established patient visit 2 of the 3 key components, **History**, **Exam**, and **Medical Decision Making**, must be met or exceeded. In this example, the two selected key components are circled in red, **History** (Focused) and **Medical Decision Making** (Straight forward) make this a 99212 encounter for the **private** payors.

Looking specifically at the **Medical Decision-Making** component, 2 of the 3 parts, **Data**, **Diagnosis**, and **Risk**, need to be met or exceeded. In this example, the two selected parts are circled in blue, **Diagnosis** (Straight Forward) and **Risk** (Straight forward) making the **MDM** component Straight Forward.

For **Medicare Telemedicine**, **MDM** is a stand-alone criterion making this **99212** without taking History or Exam into consideration. (Or time can be documented and used as stand-alone criterion for privates or Medicare.)

• CC: R ankle pain 1

• **HPI:** The ankle is feeling better **1**

Exam: Deferred

• Impression: Ankle sprain resolved.

Plan: F/U PRN.

• MDM: Straight Forward.

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

Table 2: ESTABLISHED PATIENT (seen in same practice / same specialty within 3 years) Minimum Documentation Requirements Key Components: History, Exam, Medical Decision Making
Only 2 of the 3 key components must be met (or exceeded) to qualify for a particular level code Code is determined by the lower of the 2 components. (left-most column of 2 components chosen). Time may be the sole determining factor in specific circumstances described below (Note: CPT code 99211 has no documentation requirements for the 3 key components.) History Chief Complaint History of Present Illness Location, Quality, Severity, Timing, Duration, Context, Modifying Factors, Associated Symptoms. Reviewof Systems (14 systems)
Symptoms NOT Diseases
Past, Family, and Social History 3 areas: Past (illness, injury, meds, surgery, allergy)/Family/Social Focused Detailed Exam Bullets (see bullet counter) Expanded Comprehensive Medical Decision Making (2 out of 3 Data, Diagnosis, Risk) Data add points (# points)

Till Order inaging and/or review reports
(Xrays, MRI, CT or MSK DX US)
(1) Order lab tests and/or review results
(blood, urine, body flush or review results
(blood, urine, body flush
(1) Order other test and/or review report
(2) Independent interpretation of outside
image. "there are no points given for interpreting in office films billed with a
global radiology code/26 modifier
(2) Review/Bummary record and/or
(7) Review Rest with performing HCP
(1) Order old records Data add points (# points) willor Problem (max of 2) (1) Established Problem-stable or bette (each) (3) New prob. no work up planned (max of 1) (4) New prob. work up planned (each) Management options selected, -Prescription Med --Surgery with -Ace Wrap Aspiration co-morbidities Diagnostic procedure ordered -Injection, no -Surgery healthy -Emergency Surgery -Lab Test -Fracture/Dislocation (no -Fracture/Dislocation (with Presenting problem -Imaging w/out manipulation) manipulation) -Imaging with IV -Joint injection with contrast contrast co-morbid Minor problem -Bone Scan (cortisone in DM) -Life or limb (simple strain o Abrupt Neuro Loss -Imaging with -1 chronic problem arthrogram -Biopsy (deep) -Acute uncomplicated 1 chronic prob with injury (e.g. simple exacerbation ankle sprain) -2 chronic probs stable Acute complicated injury (e.g. ACL tear) Code Need 2/3 key components for note. Lov 99213 99214 99215 component determines code Time (minimum in minutes) Can be standalone factor. Must document that face to face and > 50% counseling and summarize the counseling provided.

Reproduced, with permission, from Davidson J. Updating guidelines and tables for office E/M coding. AAOS Now. 2010 Aug 1.

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Example 2. In an established patient visit 2 of the 3 key components must be met or exceeded. In this example, the two selected key components are circled in red, **History** (Expanded) and **Medical Decision Making** (Low complexity) making this a 99213 encounter for the private payors.

Looking specifically at the **Medical Decision Making** component, 2 of the 3 parts must be met or exceeded. In this example, the two selected parts are circled in blue, **Data** (Moderate Complexity) and **Risk** (Low Complexity) making the **MDM** component Low complexity.

For Medicare Telemedicine, MDM is a stand alone criterion making this 99213 without taking History or Exam into consideration.

(Or time can be documented and used as stand alone criterion for privates or Medicare)

• CC: R Shoulder pain 1

Page 2

- HPI: The patient follows up. His pain is stable. Pain localized laterally. Worse with overhead motion. 3
- ROS: Pulmonary: No cough 1
- PE: Right Shoulder: Standing can forward flex to 150. 1
- **Data:** MRI to my independent review partial tear of supra. The radiologist report is reviewed stating tendinopathy of the supra.
- Impression: Rotator cuff partial tear.
- Plan: HEP described for ROM and strengthening. Use over the counter medication prn. Recheck in four weeks.
- MDM: Low.

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

| Code is determined by the lower of the 2 components (left-most column of 2 components chosen). Time may be the sole determining factor in specific circumstances described below. (Note: CPT code 99211 has no documentation requirements for the 3 key components.) | | | | | | |
|---|--|--|--|------------------|--|--|
| History | Focused | Expanded | Detailed | Comprehensive | | |
| Chief Complaint History of Present Illness Location, Quality, Severity, Timing, Duration, Context, Modifying Factors, Associated Symptoms. | *1 *1 | | 1 4 | 4 | | |
| Review of Systems (14 systems) Symptoms NOT Diseases Past, Family, and Social History | | 1 | 2 | 10 | | |
| 3 areas: Past (illness, injury, meds, surgery, allergy) / Family/ Social | | | | | | |
| Exam | Focused | Expanded | Detailed | Comprehensiv | | |
| Bullets (see bullet counter) | | 6 | 12 | 30 all as define | | |
| Medical Decision Making (2 out of 3 Data, Diagnosis, Risk) | Straight Forward | Low | Moderate | High | | |
| Data add points (# points (*) (*) Order imaging and/of (eview reports (Xrays, MR), C1 or MSK b. 100 (*) (*) Order lab tests and/or review results (*) Order other tests and/or review report (*) Order other tests and order other order of tests with performing HCP (*) Order old records | | | | 4 | | |
| Diagnosis add points (# points) (1) Established Problem—stable or better (each) (2) Estab. Proc.—worse (each) (3) New prob. nowork up planned (max of 1) (6) New prob. work up planned (each) | | 2 | 3 | 4 | | |
| Risk Management options selected, Or Diagnostic procedure ordered Or Presenting problem | -Rest -Ace Wrap -Lab Test -Imaging w/out contrast -Minor problem (simple strain or contusion) | -OTC Injection, no co morbid Imaging with IV contrast -Bone Scan -Biopsy (superficial) -1 chronic problem stable -Acute uncomplicated injury (e.g. simple ankle sprain) | Aspiration Surgery healthy -Fracture/Dislocation (no manipulation) aging with IV trast in es Scan oppsy (superficial) chronic problem obtained by the composition of the manipulation of the scan oppsy (superficial) -limaging with arthrogram obtained by the composition of the manipulation of the composition of the com | | | |
| | | ainte sprairi | -2 chronic probs stable - Acute complicated injury (e.g. ACL tear) | | | |
| Code Need 2/3 key components for note. Lowest component determines code. | 99212 | 99213 | 99214 | 99215 | | |

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Example 3. In an established patient visit 2 of the 3 key components must be met or exceeded. In this example, the two selected key components are circled in red, **History** (Detailed) and **Medical Decision Making** (Moderate complexity) making this a 99214 encounter for the **private payors**.

Looking specifically at the **Medical Decision Making** component, 2 of the 3 parts must be met or exceeded. In this example, the two selected parts are circled in blue, **Data** (Moderate Complexity) and **Risk** (Moderate Complexity) making the **MDM** component Moderate complexity. For **Medicare Telemedicine**, **MDM** is a stand alone criterion making this **99214** without taking History or Exam into consideration

(Or time can be documented and used as stand alone criterion for privates or Medicare)

- CC: Left knee pain
- **HPI:** Follow up visit. 25 year old recreational tennis player. pain with jogging. Sharp pain. Localized medially. Pain scale 5/10. Worsening. 5
- **ROS:** Neuro: no numbness, CV: no calf swelling 2
- **PFSH:** working from home. 1
- **PE:** Alert and oriented, Appears stated age, left knee in sitting position can fully extend and flex to 120, Walks with limp. 4 See next page for PE bullet counter.
- Data: MRI reviewed independently: Medial Meniscus Tear.

Rad. Report: MMT.

- Impression: MMT
- Plan: Scope with PMM when elective schedule is reopened.
- Informed Consent: Discussed risks, benefits, rehab ...
- MDM: Moderate

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

| Time may be the sole determining factor in s (Note: CPT code 99211 has no documen | pecificcircumstand tation requireme | es described below. nts for the 3 key compor | nents.) | |
|--|---|---|--|---|
| History | Focused | Expanded | Detailed | Comprehensive |
| Chief Complaint History of Present Illness Location, Quality, Severity, Timing, Duration, Context, Modifying Factors Associated Symptoms | 1 | 1 | 1 4 | 1 4 |
| Review of Systems (14 systems) Symptoms NOT Diseases Past, Family, and Social History 3 areas: Past (illness, injury, meds, surgery, allergy)/Family/Social | | 1 | 1 | 10 |
| Exam | Focuse | Expanded | Detailed | Comprehensive |
| Bullets (see bullet counter) | 1 | 6 | | 30 all as defined |
| Medical Decision Making (2 out of 3 Data, Diagnosis, Risk) | Sumgen | Low | Moderate | High |
| Data add points (# pg es) (1) Order inaging at for review reports Xrays, MRI, CT of MS, 1. (1) Order lab tests and/or review results (1) Order lab tests and/or review results (1) Order lab tests and/or review report (EKC, NCS/EMG, dopper (2) Independent interpretation or outside image, there are no points on for global radiology code/26 modifier (2) Review/Summary record and/order (3) Review/Summary record and/order (4) Review test with personn with HCP (1) Order old records | Forward 1 | 2 | 3 | 4 |
| Diagnosis add points (# points) (1) Minor Problem (max of 2) (1) Established Problem—stable or better (veacl) (2) Estab. Prob.—worse(ear) (3) Tren posmorosurup pranned (max of 1) (4) New prob. workup planned (each) | 1 | 2 | 3 | 4 |
| RISK Management options selected, Or Diagnostic procedure ordered Or Presenting problem | -Rest -Ace Wrap -Lab Test -Imaging wout contrast -Minor problem (simple strain or contusion) | -OTC -PT -Injection, no co morbid -Imaging with IV contrast -Bone Scan -Biopsy (superficial) -1 chronic problem stable -Acute uncomplicated injury (e.g. simple ankle sprain) | -Prescription MedSurgery healthy manipulation) -Joint injection with co-morbid (cortisone in DM) -Imaging with arthrogram -Bopsy (deep) -1 chronic prob with exacerbation -2 chronic probs stable - Acute complicated injury (e.g. ACL tear) | -Surgery with co-morbidities imergency Surgery -Fracture/Dislocation (w manipulation) -Life or limb Abrupt Neuro Loss |
| Code | | | | |
| Need 2/3 key components for note. Lowest component determines code. | 99212 | 99213 | 99214 | 99215 |

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Example 3 MSK Exam bullet counter

| Physical Exam Elements | Bullet count | | | | | | | |
|---|--------------|------|-----|-----|-----|-----|--|--|
| Vital Signs (at least 3: BP, T, P, R, Ht, Wt.) | 1 | | | | | | | |
| | 1 | | | | | | | |
| Orientation X 3 | 1 | | | | | | | |
| Mood and Affect | 1 | | | | | | | |
| Gait and Station | 1 | | | | | | | |
| Body Area | neck | back | RUE | LUE | RLE | LLE | | |
| Inspection/Palpation (Note: misalignment, asymmetry, crepitation, defects, tenderness, masses or effusions, etc.) | 1 | 1 | 1 | 1 | 1 | 1 | | |
| Range of Motion (Note: pain -eg. with straight leg raising-, crepitation or contracture, etc.) | 1 | 1 | 1 | 1 | 1 | 1 | | |
| Stability (Note laxity, subluxation/dislocation, etc.) | 1 | 1 | 1 | 1 | 1 | 1 | | |
| Strength (Note atrophy, abnormal movements, flaccid, cog wheel, spastic, etc.) | 1 | 1 | 1 | 1. | 1 | 1 | | |
| Skin (Note scars, rashes, lesions, cafe-au-liat spots, ulcers, etc) | 1 | 1 | 1 | 1. | 1 | 1 | | |
| CV (any 1: pulse, temp, edema, varicosities) | 1 | | | | | | | |
| Lymph (nodes at least one area) | 1 | | | | | | | |
| Sensation | 1 | | | | | | | |
| DTR and Pathologic Reflexes | 1 | | | | | | | |
| Coordination and Balance | 1 | | | | | | | |
| Total | 40 | | | | | | | |

Note 1: As a minimum, for a comprehensive exam all 4 bullets (Inspect/palpate, ROM, Stability, and Strength) plus Skin in 4 body areas for 20 bullets must be documented. In addition, all 10 other exam elements highlighted in grey boxes must be documented.

Note 2: Documentation of multiple joints in the same body area is only 1 bullet for each descriptor (Inspect/palpate, ROM, Stability, Strength). Example, ROM of right shoulder, R elbow and R wrist is one bullet, but ROM R shoulder, L shoulder, R knee, L knee, neck, and back is 6.

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Page 5

summarize the counseling provided

Table 1. NEW PATIENT & CONSULTATION Minimum Documentation Requirements: Key Components: History, Exam, Medical Decision making All 3 key components must be met (or exceeded) to qualify for a coding level of service. Code is determined by the lowest of the 3 components. (left-most column). Time may be the sole determining factor in specific circumstances described below Comprehensive Comprehensive Chief Complaint History of Present Illness Location, Quality, Severity, Timing, Duration, Context, Modifying Factors, Associated Symptoms. Reviewof Systems (14 systems Symptoms NOT Diseases Past, Family, and Social History 3 areas: Past (illness, injury, meds. surgery, allergy) / Family/ Social Detailed Comprehensive Exam Focused Expan Comprehensive Bullets (see bullet counter 30 all as defined 30 all as defined Medical Decision Making (2 out of 3 Data, Diagnosis, Risk) Straight Forward Low Forward Moderate High Data add noints (# noints) 7., order imaging and/or ... view reports (Xrays, MRI, CT or M. K DX (1) Order lab tosts and/or review results (blood, urine, body fluid) (1) Order other test and/ or review report (EKG, NCS/EMG, doppler) (2) Independent interpretation of outside image. * there are no points given for interpreting in office films billed with a global radiology code/26 modifier (2) Review/Summary record and/or History from other/discussion with (1) Review test with performing HCP (1) Order old records Diagnosis add points (# points) (1) Minor Problem (max of 2) (1) Established Problem-stable or better (each) (3) New prob. no work up planned (1 max) Newprob. workup planned (each) Management options selected, Rest -OTC -Prescription Med -Surgery with -Ace Wrap -Aspiration co-morbidities Ace Wrap Diagnostic procedure ordered -Injection no -Emergency Surgery -Surgery healthy -Lab Test -Lab Test co-morbid -Fracture/Dislocation -Fracture/Dislocation Presenting problem Imaging w/out -Imaging w/out (no manipulation) (with manipulation) contrast contrast Imaging with IV Joint injection contrast with co-morbid -Life or limb -Bone Scan (cortisone in DM) -Abrupt Neuro Loss -Minor problem -Minor problem -Biopsy (superficial) (simple strain (simple strain -Imaging with or contusion) or contusion) 1 chronic problem Arthrogram stable, -Biopsy (deep) -Acute uncomplicated injury -1 chronic (simple ankle sprain) exacerbation. -2 chronic probs stable. -Acute complicated injury (ACL tear) Code Need 3/3 kev components for note N 99204 N 99201 N 99202 N 99203 N 99205 Lowest component determines code C 99241 C 99242 C 99244 Time (minimum in minutes) Can be stand-C 30 C 40 C 60 C 80 alone factor. Must document that face to face and > 50% counseling and

Example 4. In a new patient visit 3 of the 3 key components, **History**, **Exam**, and **Medical Decision Making** must be met or exceeded. In this example, the three key components are circled in red, **History** (Detailed), **Exam** (Expanded), and **Medical Decision Making** (Low complexity) making this a 99202 encounter for the private payors.

Looking specifically at the **Medical Decision Making** component, 2 of the 3 parts, **Data**, **Diagnosis**, and **Risk** must be met or exceeded. In this example, the two selected parts are circled in blue, **Diagnosis** (Moderate complexity) and **Risk** (Low complexity) making the **MDM** component Low complexity.

For **Medicare Telemedicine**, **MDM** is a stand alone criterion making this **99203** without taking History or Exam into consideration.

(Or time can be documented and used as stand alone criterion for privates or Medicare)

- CC: "my left knee hurts" 1
- HPI: Twisted knee on stairs last week. Pain localized medially. Improving. 4
- **ROS:** CV: no calf pain or swelling. Neuro: No numbness 2
- **PFSH:** Working from home 1
- **PE:** A+O, appears age of 40, Mood and affect wnl, He walks with a left limp. (See next page for PE bullet counter)

<u>Left knee</u>: Skin without lesion, well aligned, mild swelling, 0-120 active ROM in sitting position

Right Knee: Skin intact, well aligned, 0-130 active ROM in sitting position 9

Data: X-ray report from ER, no fracture.

- **Impression**: New patient with knee sprain improving rapidly.
- Plan: We will obtain x-ray already done in ER for independent review. Take OTC prn. Instructed on HEP. Follow up telemedicine in 2 weeks. MDM: Low.

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

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Example 4 MSK Exam bullet counter

| Di ' 1 E Ei | T) 11 / | | | | | | | |
|---|---------|--------------|-----|-----|-----|-----|--|--|
| Physical Exam Elements | | Bullet count | | | | | | |
| Vital Signs (at least 3: BP, T, P, R, Ht, Wt.) | 1 | | | | | | | |
| General Appearance | 1 | | | | | | | |
| Orientation X 3 | 1 | | | | | | | |
| Mood and Affect | | | | | | | | |
| Gait and Station | | | | | | | | |
| Body Area | neck | back | RUE | LUE | RLE | LLE | | |
| Inspection/Palpation (Note: misalignment, asymmetry, crepitation, defects, tenderness, masses or effusions, etc.) | 1 | 1 | 1 | 1 | 1 | 1 | | |
| Range of Motion (Note: pain -eg. with straight leg raising-, crepitation or contracture, etc.) | 1 | 1 | 1 | | | 1 | | |
| Stability (Note laxity, subluxation/dislocation, etc.) | 1 | 1 | 1 | 1 | 1 | 1 | | |
| Strength (Note atrophy, abnormal movements, flaccid, cog wheel, spastic, | 1 | 1 | 1 | 1 | 1 | 1 | | |
| etc.) | | | | | | | | |
| Skin (Note scars, rashes, lesions, cafe-au-liat spots, ulcers, etc) | 1 | 1 | 1 | 1. | 1 | 1 | | |
| CV (any 1: pulse, temp, edema, varicosities) | 1 | | | | | | | |
| Lymph (nodes at least one area) | 1 | | | | | | | |
| Sensation | 1 | | | | | | | |
| DTR and Pathologic Reflexes | 1 | | | | | | | |
| Coordination and Balance | 1 | | | | | | | |
| Total | 40 | | | | | | | |

Note 1: As a minimum, for a comprehensive exam all 4 bullets (Inspect/palpate, ROM, Stability, and Strength) plus Skin in 4 body areas for 20 bullets must be documented. In addition, all 10 other exam elements highlighted in grey boxes must be documented.

Note 2: Documentation of multiple joints in the same body area is only 1 bullet for each descriptor (Inspect/palpate, ROM, Stability, Strength). Example, ROM of right shoulder, R elbow and R wrist is one bullet, but ROM R shoulder, L shoulder, R knee, L knee, neck, and back is 6.