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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	Focused	Expanded	Detailed	Comprehensive
Chief Complaint	1	1	1	1
History of Present Illness Location, Quality, Severity, Timing, Duration, Context, Modifying Factors, Associated Symptoms.	1	1	4	4
Review of Systems (14 systems) *Symptoms NOT Diseases*		1	2	10
Past, Family, and Social History 3 areas: **Past** (illness, injury, meds, surgery, allergy) / **Family**/ **Social**			1	2
Exam	**Focused**	**Expanded**	**Detailed**	**Comprehensive**
Bullets (see bullet counter)	1	6	12	30 all as defined
Medical Decision Making (2 out of 3 Data,Diagnosis,Risk)	**Straight Forward**	**Low**	**Moderate**	**High**
Data add points (# points) (1) Order imaging and/or review reports (Xrays, MRI, CT or MSK DX US) (1) Order lab tests 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 HCP (1) Review test with performing HCP (1) Order old records		2	3	4
Diagnosis add points (# points) (1) Minor Problem (max of 2) (1) Established Problem—stable or better (each) (2) Established Problem—worse (not improving) (each) (3) New prob. no work up planned (max of 1) (4) New prob. work up planned (each)	1	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 -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 Med - Aspiration -Surgery healthy -Fracture/Dislocation (no manipulation) -Joint injection with co-morbid (cortisone in DM) -Imaging with arthrogram -Biopsy (deep) -1 chronic prob with exacerbation -2 chronic probs stable - Acute complicated injury (e.g. ACL tear)	-Surgery with co-morbidities -Emergency Surgery -Fracture/Dislocation (with manipulation) -Life or limb Abrupt Neuro Loss
Code Need **2/3 key components** for note. Lowest component determines code.	99212	99213	99214	99215
Time (minimum in minutes) Can be stand-alone factor. Must document that face to face and > 50% counseling and summarize the counseling provided.	10	15	25	40

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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**
- 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.

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	Focused	Expanded	Detailed	Comprehensive
Chief Complaint	1	1	1	1
History of Present Illness Location, Quality, Severity, Timing, Duration, Context, Modifying Factors, Associated Symptoms.	1	1	4	4
Review of Systems (14 systems) *Symptoms* NOT *Diseases*		1	2	10
Past, Family, and Social History 3 areas: **P**ast (illness, injury, meds, surgery, allergy) / **F**amily/ **S**ocial			1	2
Exam	**Focused**	**Expanded**	**Detailed**	**Comprehensive**
Bullets (see bullet counter)	1	6	12	30 all as defined
Medical Decision Making (2 out of 3 Data, Diagnosis, Risk)	**Straight Forward**	**Low**	**Moderate**	**High**
Data add points (# points) (1) Order imaging and/or review reports (Xrays, MRI, CT or MSK DX US) (1) Order lab tests 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 HCP (1) Review test with performing HCP (1) Order old records	1	2	3	4
Diagnosis add points (# points) (1) Minor Problem (max of 2) (1) Established Problem—stable or better (each) (2) Estab. Prob.—worse (each) (3) New prob. no workup planned (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 w/out 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 Med -Aspiration -Surgery healthy -Fracture/Dislocation (no manipulation) -Joint injection with co-morbid (cortisone in DM) -Imaging with arthrogram -Biopsy (deep) -1 chronic prob with exacerbation -2 chronic probs stable - Acute complicated injury (e.g. ACL tear)	-Surgery with co-morbidities -Emergency Surgery -Fracture/Dislocation (with manipulation) -Life or limb Abrupt Neuro Loss
Code Need **2/3 key components** for note. Lowest component determines code.	99212	99213	99214	99215
Time (minimum in minutes) Can be stand-alone factor. Must document that face to face and > 50% counseling and summarize the counseling provided.	10	15	25	40

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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 Telemedicin**e, **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.

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	Focused	Expanded	Detailed	Comprehensive
Chief Complaint	1	1	1	1
History of Present Illness Location, Quality, Severity, Timing, Duration, Context, Modifying Factors, Associated Symptoms.	1	1	4	4
Review of Systems (14 systems) *Symptoms NOT Diseases*		1	2	10
Past, Family, and Social History 3 areas: Past (illness, injury, meds, surgery, allergy) / Family / Social			1	2
Exam	**Focused**	**Expanded**	**Detailed**	**Comprehensive**
Bullets (see bullet counter)	1	6	[illegible]	30 all as defined
Medical Decision Making (2 out of 3 Data, Diagnosis, Risk)	**Straight Forward**	**Low**	**Moderate**	**High**
Data add points (# points) (1) Order imaging and/or review reports (Xrays, MRI, CT or MSK Ultrasound) (1) Order lab tests and/or review results (blood, urine, body fluid) (1) Order tests and/or review report (EKG, NCS/EMG, doppler) (2) Independent interpretation of outside image. * there are no points given for [illegible] billed with a global radiology code/26 modifier (2) Review/Summary record and/or History from other/discussion with HCP (1) Review test with performing HCP (1) Order old records	1	2	3	4
Diagnosis add points (# points) (1) Minor Problem (max of 2) (1) Established Problem—stable or better (each) (2) Estab. Prob.—worse (each) (3) New prob. w/u planned (max of 1) (4) New prob. w/u planned (each)	1	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 -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 Med - Antibiotic -Surgery healthy -[illegible] manipulation) -Joint injection with co-morbid (cortisone in DM) -Imaging with arthrogram -Biopsy (deep) -1 chronic prob with exacerbation -2 chronic probs stable - Acute complicated injury (e.g. ACL tear)	-Surgery with co-morbidities -Emergency Surgery -Fracture/Dislocation (with manipulation) -Life or limb Abrupt Neuro Loss
Code Need **2/3 key components** for note. Lowest component determines code.	99212	99213	99214	99215
Time (minimum in minutes) Can be stand-alone factor. Must document that face to face and > 50% counseling and summarize the counseling provided.	10	15	[illegible]	40

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Example 3 MSK Exam bullet counter

Musculoskeletal Exam Bullet counter						
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	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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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.

History	Focused	Expanded	Detailed	Comprehensive	Comprehensive
Chief Complaint	1	1	1	1	1
History of Present Illness Location, Quality, Severity, Timing, Duration, Context, Modifying Factors, Associated Symptoms.	1	1	4	4	4
Review of Systems (14 systems) *Symptoms* NOT *Diseases*		1	2	10	10
Past, Family, and Social History 3 areas: **P**ast (illness, injury, meds, surgery, allergy) / **F**amily/ **S**ocial			1	3	3

Exam	Focused	Expanded	Detailed	Comprehensive	Comprehensive
Bullets (see bullet counter)	1	6	12	30 all as defined	30 all as defined

Medical Decision Making (2 out of 3 Data,Diagnosis,Risk)	Straight Forward	Straight Forward	Low	Moderate	High
Data add points (# points) (1) Order imaging and/or review reports (Xrays, MRI, CT or MSK DX US) (1) Order lab tests 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 HCP (1) Review test with performing HCP (1) Order old records	1	1	2	3	4
Diagnosis add points (# points) (1) Minor Problem (max of 2) (1) Established Problem—stable or better (each) (2) Estab. Prob.—worse (each) (3) New prob. no work up planned (1 max) (4) New prob. work up planned (each)	1	1	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)	-Rest -Ace Wrap -Lab Test -Imaging w/out 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 (simple ankle sprain)	-Prescription Med -Aspiration -Surgery healthy -Fracture/Dislocation (no manipulation) -Joint injection with co-morbid (cortisone in DM) -Imaging with Arthrogram -Biopsy (deep) -1 chronic exacerbation, -2 chronic probs stable, -Acute complicated injury (ACL tear)	-Surgery with co-morbidities -Emergency Surgery -Fracture/Dislocation (with manipulation) -Life or limb -Abrupt Neuro Loss
Code Need **3/3 key components** for note. Lowest component determines code.	N 99201 C 99241	N 99202 C 99242	N 99203 C 99243	N 99204 C 99244	N 99205 C 99245
Time (minimum in minutes) Can be stand-alone factor. Must document that face to face and > 50% counseling and summarize the counseling provided.	N 10 C 15	N 20 C 30	N 30 C 40	N 45 C 60	N 60 C 80

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 Telemedicin**e, **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)**

  Left knee : 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

Musculoskeletal Exam Bullet counter						
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	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.						