

Simplified Coding

28 Jan 2011

NOTE: Clinical necessity determines your work. Do not work toward a code.

■ **A “Yes” response to any one of the items below gives a 99214 * (Est Pt)****

- 3 Established Problems Stable or Improving (addressed in Subj)
- 1 Established Problem + 1 Established Problem Worsening (both addressed in Subj)
- 1 New Problem (not self-limited or minor, new to the provider) + Rx (not OTC med)
- Review and Summation of Old Note + Rx (not OTC med)
- Order Rad/ECG + Independent Review + Rx (not OTC med)

*Three assumptions: 1. Detailed History has been accomplished (CC:4:2:1) 2. This is an established patient 3. CODING IS BASED UPON DOCUMENTATION IN THE NOTE (eg., new problem must be stated as such in note,etc)

**If the answer is “no” to all questions above, the code is a 99213 UNLESS the patient has 1. Only one problem which is self-limited/established stable AND 2. Minimal data review or minimal management (rest/Band-Aids, salt water gargles, etc.)- then it is a 99212

■ **A “Yes” response to any one of the items below gives a 99203 * (New Pt)**

- 2 Established Problems Stable or Improving (addressed in Subj)
- 1 Established Problem Worsening (addressed in Subj) + OTC med
- 1 New Problem (not self-limited or minor, new to the provider) + OTC med
- Review and Summation of Old Note + OTC med
- Order Rad/ECG + Independent Review + OTC med

*Three assumptions: 1. Detailed History has been accomplished (CC:4:2:1) 2. Detailed Exam has been done (12 bullets in 2 systems or 2 bullets in 6+ systems- all clinically appropriate) 3. CODING IS BASED UPON DOCUMENTATION IN THE NOTE (eg., new problem must be stated as such in note, etc)

■ **A “Yes” response to any one of the items below gives a 99204* (New Pt)**

- 3 Established Problems Stable or Improving (addressed in Subj)
- 1 Established Problem + 1 Established Problem Worsening (both addressed in Subj)
- 1 New Problem (not self-limited or minor, new to the provider) + Rx (not OTC med)
- Review and Summation of Old Note + Rx (not OTC med)
- Order Rad/ECG + Independent Review + Rx (not OTC med)

*Three assumptions: 1. Comprehensive History has been accomplished (4 elements of HPI + 10 system ROS + complete PFSH-Medical/Surgical/Family history documented) 2. Comprehensive Exam has been done (2 bullets from EACH of 9 systems- all clinically appropriate) 3. CODING IS BASED UPON DOCUMENTATION IN THE NOTE (eg., new problem must be stated as such in note, etc)

To Override AHLTA's Coding Calculator

4 Nov 2009

From the Disposition screen select the SELECTION tab

Now highlight the code you want to assign to this encounter.

Meets Outpt Visit Criteria (Workload)? Yes

Office/Outpatient Visit

Selection E&M Code: 99214 (Est Outpatient Visit, Lvl 4)

E&M Codes:

E&M	Evaluation & Management
99201	New Outpatient Visit, Lvl 1
99202	New Outpatient Visit, Lvl 2
99203	New Outpatient Visit, Lvl 3
99204	New Outpatient Visit, Lvl 4
99205	New Outpatient Visit, Lvl 5
99211	Est Outpatient Visit, Lvl 1 (& non-privileged providers)
99212	Est Outpatient Visit, Lvl 2
99213	Est Outpatient Visit, Lvl 3
99214	Est Outpatient Visit, Lvl 4
99215	Est Outpatient Visit, Lvl 5

E&M Description: Established, Outpatient Visit
2 of 3: Detailed Hx, Detailed Exam, Moderate Complexity MDM
Moderate/High Severity Problem(s)
Typically 25 minutes

Sample Procedures with RVU's

Tobacco Cessation Counseling (3-10 min)	0.24 RVU	99406 (Disposition E&M)
Tobacco Cessation Counseling (10+ min)	0.50 RVU	99407 (Disposition E&M)
Cerumen Removal requires provider skill	0.61 RVU	69210
Skin Tag Removal up to 15 lesion	0.79 RVU	11200
Shave Skin Lesion (site & length required)	1.05 RVU	11300-11313
I&D Abscess	1.19 RVU	10060
Bx, Skin, Tiss/Mucous Membr	0.81 RVU	11100
IV Fluid, 1 hour for hydration	0.17 RVU	96360
ECG w/interpretation and report	0.17 RVU	93000
Cryosurgery of Skin up to 14 lesions	0.67 RVU	17110
Screening Pap Obtain	0.37 RVU	Q0091 (HCPCS)
IM/SC Injection	0.17 RVU	96372
Digital Rectal Exam (annual)	0.17 RVU	S0605 (HCPCS)
Foot Incision FB in Foot (splinter)	1.98 RVU	28190
Drainage finger abscess (felon)	2.21 RVU	26011
Surgery penile lesion destruction (cryosurgery)	1.26 RVU	54050
Ablation vulvar lesion (cryosurgery)	1.55 RVU	56501
Skin debridement	0.80 RVU	11042
Closed tx of phalanx fx	1.12 RVU	28510
Closed tx of great toe	1.12 RVU	28490
Incision & removal of foreign body, subcutaneous, simple	1.23 RVU	10120
Excision of nail/matrix, permanent	2.40 RVU	11750
Repair Superficial Wound (site & length req)	1.38 RVU	12001-12020
Drain/Inject Joint/Bursa (major joint)	0.79 RVU	20610
Removal of Sperm duct(s) Vasectomy	3.32 RVU	55250 (2009 CPT code)

Updated 10 Nov 09 from: http://www.cms.hhs.gov/pfslookup/02_PFSsearch.asp