

GENERAL EXAM - POCKET GUIDE

Required Documentation Components

HIISTORY Component	EXAM Component	MEDICAL DECISION MAKING Component			
History of Presenting Illness (HPI): <ul style="list-style-type: none"> • Location • Quality • Severity (1-10) • Duration • Timing • Context • Modifying Factors • Associated S/S <p>*or the Status of 3 chronic problems/diseases – must use 1997 exam bullets</p>	1995 Body Areas & Organ Systems Body Areas Head, incl. face Neck Chest, incl. Breasts & Axillae Abdomen Genitalia, groin, buttocks Back, inc. spine Each extremity Organ Systems Constitutional (eg, vital signs, general appearance) Eyes Ears/Nose/Mouth/Throat Cardiovascular Respiratory Gastrointestinal Genitourinary Musculoskeletal Skin Neurologic Psychiatric Hematologic/Lymphatic/Immunologic	Must have 2 of 3 to select level			
	Example of 1997 bullets for a General exam (Each • counts as one bullet) Constitutional: • Any three vital signs • General appearance of patient Eyes: • Conjunctivae & lids • Pupils & irises • Optic discs ENT: • External ears & nose • EACs & TMs • Hearing • Nasal mucosa, septum & turbinates • Lips, teeth & gums • Oropharynx Neck: • Neck • Thyroid Resp: • Respiratory effort • Percussion • Palpation • Auscultation CV: • Palpation of heart • Auscultation • Carotids • Abdominal aorta • Femoral • Pedal pulses • Extremities for edema &/or varicosities Chest (Breast): • Inspection of breasts • Palpation of breasts & axillae GI (Abdomen): • Masses, tenderness • Liver & spleen • Hernia • Anus, perineum & rectum • Occult test, If indicated GU: Male • Scrotal contents • Penis • Prostate gland Female • External genitalia • Urethra • Bladder • Cervix • Uterus • Adnexa/parametrium Lymph: Lymph nodes in two or more areas: • Neck • Axillae • Groin • Other Musc: • Gait & station • Digits & nails Joint(s), bone(s), muscle(s) of one or more of the following six areas: 1)head/neck 2)spine/ribs/pelvis 3) R upper extremity 4) L upper extremity 5) R lower extremity 6) L lower extremity, with exam including: • Inspection &/or palpation • ROM • Stability • Strength/tone Skin: • Inspection of skin & subq tissue • Palpation of skin & subq tissue Neuro: • Cranial nerves • Reflexes • Sensation Psych: • Judgment & insight • Orientation to time, place & person • Memory • Mood & affect	Number of Diagnosis or Treatment Options	Amount and/or complexity of data reviewed	Risk of complication and/or morbidity or mortality	Type of Decision Making
Review of Systems (ROS): <ul style="list-style-type: none"> • Constitutional • Eyes • Ears/Nose/Mouth/Throat • Cardiovascular • Respiratory • Gastrointestinal • Genitourinary • Musculoskeletal • Integumentary • Neurological • Psychiatric • Endocrine • Hematological/Lymphatic • Allergic/Immunology 		Minimal	Minimal	Minimal	Straight-forward
Past Medical/Family/Social History (PFSH): <ul style="list-style-type: none"> • Past Medical / Surgical • NKDA / Medications • Family History • Social History 		Limited	Limited	Low	Low
		Multiple	Moderate	Moderate	Moderate
		Extensive	Extensive	Extensive	High
		COUNSELING & COORDINATION OF CARE (TIME BASED BILLING)			
		When you can bill based on time: If greater than 50% of your visit with the patient consisted of counseling and/or coordinating care then you MUST document the time spent with the patient and that greater than 50% was spent counseling or coordinating their care and what you discussed with the patient. When correctly documented then you may choose the correct EM level based on time. The codes are listed below with the required time. This is only to be used when greater than <u>50% of the visit was spent counseling and/or coordinating</u> the patient's care.			
		99201 = 10 min	99211 = Nurse's Visit		
		99202 = 20 min	99212 = 10 min		
		99203 = 30 min	99213 = 15 min		
		99204 = 45 min	99214 = 25 min		
		99205 = 60 min	99215 = 40 min		

OFFICE SERVICES	HOSPITAL SERVICES	NURSING HOME SERVICES
<p>New Patients</p> <p>99201 History = CC, 1-3 HPI, No ROS, No PFSH Exam =1 body system/area or 1-5 bullets MDM = Straightforward</p> <p>99202 History = CC, 1-3 HPI, 1 ROS, No PFSH Exam = 2-4 body system/areas or 6+ bullets MDM = Straightforward</p> <p>99203 History = CC, 4+ HPI 2-9 ROS, 1-2 PFSH *or the status of 3 chronic problems Exam = 5-7 body systems/area or 12+ bullets MDM = Low Complexity</p> <p>99204 History = CC, 4+ HPI, 10+ ROS, 3 PFSH * or the status of 3 chronic problems Exam = 8+ body systems/areas or 18 bullets MDM = Moderate Complexity</p> <p>99205 History = CC, 4+ HPI, 10+ ROS, 3 PFSH * or the status of 3 chronic problems Exam = 8+ body systems/areas or 18 bullets MDM = High Complexity</p> <p>Established Patients</p> <p>99211 = Nurse’s Visit</p> <p>99212 History = CC, 1-3 HPI, No ROS, No PFSH Exam =1 body system/area or 1-5 bullets MDM = Straightforward</p> <p>99213 History = CC, 1-3 HPI, 1 ROS, No PFSH Exam = 2-4 body system/areas or 6+ bullets MDM = Low Complexity</p> <p>99214 History = CC, 4+ HPI, 2-9 ROS, 1 PFSH * or the status of 3 chronic problems Exam = 5-7 body systems/area or 12+ bullets MDM = Moderate Complexity</p> <p>99215 History =CC, 4+ HPI, 10+ ROS, 3 PFSH * or status of 3 chronic problems Exam = 8+ body systems/areas or 18 bullets MDM= High Complexity</p>	<p>Admit (H&P)</p> <p>99221 History =CC, 4+ HPI, 2-9 ROS, 2-3 PFSH Exam = 5-7 body systems/areas or 12+ bullets MDM = Straightforward or Low Complexity</p> <p>99222 History = CC, 4+ HPI, 10+ ROS, 3 PFSH Exam = 8+ body systems/areas or 18+ bullets MDM = Moderate Complexity</p> <p>99223 History = CC, 4+ HPI, 10+ ROS, 3 PFSH Exam = 8+ body systems/areas or 18+ bullets MDM = High Complexity</p> <p>Subsequent Visits</p> <p>99231 “Interval” History = 1-3 HPI, No ROS, No PFSH Exam =1 body system/area or 1-5 bullets MDM = Straightforward or Low Complexity</p> <p>99232 “Interval” History = 1-3 HPI, 1 ROS, No PFSH Exam = 2-4 body system/areas or 6+ bullets MDM =Moderate Complexity</p> <p>99233 “Interval” History = 4+ HPI , 2-9 ROS, 1-2 PFSH Exam = 5-7 body systems/areas or 12 + bullets MDM= High Complexity</p> <p>Discharge 99238 = 30 min or less 99239 = greater than 30 minutes</p> <p>Office/ Inpatient Consultation</p> <p>99241/ 99251 History = CC, 1-3 HPI, No ROS, No PFSH Exam =1 body system/area or 1-5 bullets MDM = Straightforward</p> <p>99242 / 99252 History = CC, 1-3 HPI, 1 ROS, No PFSH Exam = 2-4 body system/areas or 6+ bullets MDM = Straightforward</p> <p>99243 / 99253 History = CC, 4+ HPI, 2-9 ROS, 1 or 2 PFSH Exam = 5-7 body systems/areas or 12+ bullets MDM = Low Complexity</p> <p>99244 / 99254 History = CC, 4+ HPI, 10+ ROS, 3 PFSH Exam = 8+ body systems/areas or 18 bullets MDM = Moderate Complexity</p> <p>99245 / 99255 History = CC, 4+ HPI, 10+ ROS, 3 PFSH Exam = 8+ body systems/areas or 18 bullets MDM = High Complexity</p>	<p>Initial Visits</p> <p>99304 – Initial Nursing Facility Per Day Detailed History =CC, 4+ HPI, 2-9 ROS, 1-2 PFSH Detailed Exam = 5-7 body systems/areas or 12 bullets MDM = Straightforward or Low Complexity</p> <p>99305 Comprehensive History =CC, 4+ HPI, 10 + ROS, 3 PFSH Comprehensive Exam = 8+ body systems/areas or 18 bullets MDM = Moderate Complexity</p> <p>99306 Comprehensive History = CC, 4+ HPI, 10+ ROS, 3 PFSH Comprehensive Exam = 8+ body systems/areas or 18+ bullets MDM = High Complexity</p> <p>Subsequent Visits</p> <p>99307 PF Interval History = 1-3 HPI, No ROS, No PFSH PF Exam =1 body system/area or 1-5 bullets MDM = Straightforward</p> <p>99308 EPF Interval History = 1-3 HPI, 1 ROS, No PFSH EPF Exam = 2-4 body system/areas or 6+ bullets MDM =Low Complexity</p> <p>99309 Detailed Interval History = 4+ HPI , 2-9 ROS, 1-2 PFSH Detailed Exam = 5-7 body systems/areas or 12 + bullets MDM= Moderate Complexity</p> <p>99310 Comprehensive Interval History = 4+HPI, 10 + ROS, 3 PFSH Comprehensive Exam = 8+ body systems/areas or 18+ bullets MDM=High Complexity</p> <p>Discharge 99315 = 30 min or less 99316 = greater than 30 minutes</p> <p>99318=Annual Nursing Facility Assessment Detailed Interval history = 4+HPI, 10+ ROS, 1-2 PFSH Comprehensive Exam = 8+ body systems/areas or 18+ bullets MDM=Low to Moderate Complexity</p> <p>Criteria needed to bill a consultation: Consultations are services rendered to give advice or an opinion to a requesting physician about a patient’s diagnosis and/or management of that condition. A consultation is distinguished from a visit when the “three R’s” are met:</p> <ol style="list-style-type: none"> 1. Request: Make it a policy to document the formal request within the medical record. This creates a clear path showing why the patient went from one doctor to another. 2. Recommendation: The physician who renders the consultation should note specifically who requested the consult, what the physician requesting the consult asked for and why the patient was sent to him/her specifically. 3. Response/Report: The doctor who performed the consult must prepare a written response, by letter or sending the medical record. The report should be submitted to the referring physician within a few days of seeing the patient.