NHIC, Corp. Evaluation & Management (E/M) Coding Requirements

NHIC, Corp. Medical Review offers this article and the attached worksheet to assist you in understanding the documentation and policy requirements associated with Evaluation & Management Services. This worksheet is a *tool* used by NHIC Medical Reviewers when adjudicating claims. Please refer to the attached NHIC Evaluation and Management Coding Worksheet which is based on the (CMS) 1995 and 1997 Guidelines.

This reference tool is intended to serve as a useful supplement to other manuals published by NHIC, and not as a replacement. The information provided in no way represents a guarantee of payment. Benefits for all claims will be based on the patient's eligibility, provisions of the Law, and regulations and instructions from Centers for Medicare & Medicaid Services (CMS). It is the responsibility of each provider or practitioner submitting claims to become familiar with Medicare coverage and requirements. All information is subject to change as federal regulations and Medicare Part B policy guidelines, mandated by CMS, are revised or implemented.

Medical Necessity of the service is the overarching criterion for payment in addition to the individual requirements of a CPT Code (CMS Manual, Publication 100-4, Chapter 12, Section 30.6.1).

Medicare Contractors may only allow payment for medically necessary and reasonable services defined by Section 1862(a) (1) (A) of the Social Security Act. Medicare Regulations indicate that no Medicare payment shall be made for items or services that are not "reasonable" and necessary for the diagnosis or treatment of illness or injury or to improve a missing or non-functioning body member. Services performed "in the absence of signs or symptoms" are excluded from payment under the Medicare Program.

Healthcare providers and practitioners who receive Medicare payment either in full or in part, have certain obligations. Those obligations should ensure that services rendered are:

- Provided economically and only when, and to the extent that, they are medically necessary.
- Meeting professionally recognized standards of health care supported by appropriate evidence of medical necessity and quality of care.

E/M Services Contain Seven Components

The E/M codes recognize seven components that translate into the work involved and, subsequently, determine the actual code selection. The first 3 of these components (history, examination, and medical decision making) are considered the **key components** in selecting a level of E/M services. The next 4 components (counseling, coordination of care, nature of the presenting problem, and time) are considered contributory factors in the majority of encounters.

Establishing Medical Necessity

The chief complaint or reason for the encounter establishes the medical necessity and reasonableness for services. It is a concise statement describing the symptom, problem, or condition, diagnosis, physician recommended need(s), or other factor that is the reason for the encounter, **usually** stated in the patient's words. It is sometimes referred to as "presenting problem." (Documentation Guidelines 1997)

The medical necessity and reasonableness of the level of service billed is directly correlated to the nature of the presenting problem.

In addition to the medical necessity and reasonableness of an E/M service, the components of History, Examination, and Medical Decision Making are the 3 key components in selecting the appropriate level of service. What this means is that we may consider the frequency of visits when evaluating the medical need for a more detailed history and examination. It is the interval history that is important, not the repeating of the family history or the patient's surgical history.

Medical Record Documentation

Medical record documentation must be complete, legible, and clearly indicate the rendered service, the extent of the service(s) performed, and must include information that supports the medical necessity of the service provided. The documentation of each patient encounter should include: the reason for the encounter and relevant history; physical examination findings; test results; assessment and clinical impression or diagnosis; plan of care; and date and legible identity of the provider.
The purpose of medical record documentation, in general, is to provide a permanent record of each patient's medical condition and treatment for medical, legal, and financial reasons. Documentation must be as clear and complete possible, so that it may be read and understood accurately. Medical record documentation is required to record pertinent facts, findings, and observations about an individual's health history, including past and present illnesses, examinations, tests, treatments, and outcomes. The medical record chronologically documents the care of the patient and is an important element contributing to high quality care. Payers insist on accurate medical record documentation to ensure that beneficiaries have received quality care and that services reported are consistent with the insurance coverage. The medical record facilitates:

- The ability of the physician and other health care professionals to evaluate and plan the patient's immediate treatment and to monitor his/her health care over time.
- Continuity of care among physicians and other health care professionals involved in the patient care.
- Appropriate utilization review and quality of care evaluations.

It cannot be stressed enough that the volume of documentation is not the sole indication of the level of service. Documentation that is aimed to meet the guidelines for payment but is excessive for the treatment of the patient on the visit in question will not increase the level assigned to that visit.

Chief Complaint (CC) or Reason for Encounter

The medical record should clearly reflect the chief complaint.

- Services performed "in the absence of signs or symptoms" are excluded from payment under the Medicare Program. The CC is a concise statement describing the symptoms, problem, condition, diagnosis, physician recommended need (s) or other factor that is the reason for the encounter, usually stated in the patient's words.
- The CC establishes and supports the medical necessity and reasonableness for the services billed to the Medicare program.

History of Present Illness (HPI)

HPI is a chronological description of the development of the patient's present illness from the first sign and/or symptom(s) to the present. HPI's are distinguished by the amount of detail needed to accurately characterize the clinical problem(s). Below are the 8 elements of HPI and a brief description of the information included in each:

- **Location** – describes where the body symptom is occurring
- **Quality** – is the character of the symptom
- **Severity** – is a rank of the symptom/pain on a scale of 1-10. Severity can also be described with terms such as severe, slight, worst I have ever encountered, etc.
- **Duration** – describes how long the symptom/pain has been present or how long it lasts.
- **Timing** – describes when the pain/symptom occurs
- **Context** – is the situation associated with the pain/symptom
- **Modifying factors** – are things done to make the symptom/pain worse or better
- **Associated signs and symptoms** – describe the symptom/pain and other things that happen when this symptom/pain occurs

Brief HPI consists of 1 to 3 elements of the HPI. Extended HPI consists of at least 4 elements of the HPI or the status of at least 3 chronic or inactive conditions.

Review of Systems (ROS)

ROS is an inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms that the patient may be experiencing or has experienced. Ancillary staff may record the ROS or it may be a form completed by the patient; however, **there must be documentation by the physician** confirming the information recorded by others.

- Per the American Medical Association (AMA) Documentation Guidelines for Evaluation and Management Services, ROS inquires about the system(s) directly related to the problem(s) identified in the HPI plus additional body systems. At a minimum the patient's positive and pertinent negative responses should be documented. For services that require a complete ROS at least 10 organ systems must be reviewed with positive or pertinent negative responses individually documented. For the remaining systems, a notation indicating "all other systems are negative" is permissible. In the absence of such a notation, at least 10 systems must be individually documented.

For purposes of ROS, the following systems are recognized:

Constitutional	Musculoskeletal
Eyes	Integumentary
Ears, Nose, Mouth, Throat	Neurological
Cardiovascular	Psychiatric
Respiratory	Endocrine
GI Gastrointestinal	Hem/Lymph (hematologic/lymphatic)
GU Genitourinary	Allergy/Immunologic

Review of Systems (ROS)

A problem-pertinent ROS inquires about the system directly related to the problem identified in the HPI.

An extended ROS inquires about the system directly related to the problem(s) in the HPI and a limited number of additional systems. (See CMS 1997 Guidelines)

A complete ROS inquires about the system(s) directly related to the problem(s) identified in the HPI plus all additional body systems (10 or more).

Past, Family, and Social History (PFSH)

Past, Family, and Social History (PFSH): Consists of 3 areas: past history, family history, and social history. If the physician is unable to obtain a history from the patient or other source, the record should describe the patient's condition or other circumstance that precludes obtaining a history.

Examination (EX) The level of E/M services are based on four types of examinations. Key Components are according to the 1995 and 1997 Guidelines.

Problem-Focused examination documentation requirements are at least 1 of the following: a limited examination of 1 affected body area/organ system and other related system(s), (1995); 1-5 elements identified in 1 or more organ system(s) or body area(s), (1997).

Expanded Problem-Focused examination requirements are at least 1 of the following: a limited exam of the affected body area/organ system and other related system(s), (1995);
at least 6 elements identified in 1 or more organ system or body area, (1997).

Detailed examination documentation requirements are at least 1 of the following: an extended exam of affected area(s) & other symptomatic/related organ system(s), (1995);
at least 6 organ systems/body areas, and with each system/area selected, documentation of at least 2 elements is expected, (1997); at least 12 elements identified in 2 or more organ system or body areas, (1997).

Comprehensive examination documentation requirements are at least 1 of the following: a general multi- (8 or more) organ systems exam or complete exam of single organ system, (1995).

All identified elements in the bold-edged boxes (1997 E/M Exam Guidelines) should be performed. Documentation requirements for the specialty exams state all of the elements in a shaded box and at least 1 element in an unshaded box.

The major differences between the 1995 and 1997 Guidelines for E/M Coding lie in the documentation of the physical examination. The 1995 Guidelines are less precise. For example, they allow the physician (and the auditor) to choose their own definitions of "detailed" examination of an organ system. On audit, this vagueness often leads to differences of opinion – even among expert coders - on the appropriate level of examination on any given chart. The 1997 guidelines are much more explicit, listing specific elements and specific counts on these elements that count toward each specific level of physical examination.

You may use either the 1995 or 1997 Guidelines. CMS has instructed its auditors to use whichever set of results is most in the physicians' favor. Thus, you may use either set of E/M Guidelines to code any given chart; however, you may not mix and match the aspects of each set of guidelines to code any given chart. I.e., you may not use the level of history from the 1997 Guidelines and the level of physical examination from the 1995. You can find the CMS Evaluation and Management Services Guide at the following website: http://www.cms.hhs.gov/MLNProducts/downloads/eval_mgmt_serv_guide.pdf

Medical Decision Making (MDM)

The documentation of the complexity of medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by the following:

- The number of possible diagnoses that require active management or affect treatment (Treatment Options.)
- The amount and/or complexity of data – medical records, diagnostic tests, and/or information that must be obtained, reviewed and analyzed. The complexity of decision making should be documented accordingly and not be inferred or implied.
- The risk of significant complications, morbidity and/or mortality, as well as the co-morbidities, associated with the patient's presenting problems, the diagnostic procedure(s) and/or the possible management options.

For each encounter, an assessment, clinical impression, or diagnosis should be documented. Physician medical decision-making is critical to determine the overall level of care provided during a patient encounter. Medical decision-making may vary on a visit-to-visit basis depending on the patient's condition and what the physician performed that day. The fact that the patient has an underlying disease or co-morbidity is significant only if their presence significantly increases the complexity of the medical decision-making. Only conditions that impact the encounter are determining factors that affect the level of E/M service. The current status of the patient's diagnosis is also a determining factor, e.g., stable, improved, worsening, etc. Clinical impressions or diagnoses need to be written, not implied. Diagnoses count in the MDM leveling only if they impact the presenting problem. The status of diagnoses is of primary importance; if not written, the assumption is that they are improving or stable.

Diagnosis:

A. For a presenting problem with an established diagnosis the record should reflect whether the problem is: improved, well-controlled, resolving, or resolved;

B. For a presenting problem without an established diagnosis, the assessment or clinical impression may be stated in the form of a differential diagnosis or as "possible," "probable," or "rule out" diagnosis.

In the case where counseling and/or coordination of care dominates (more than 50%) of the physician/patient and/or family encounter (face-to-face time in the office or outpatient setting, floor/unit time in the hospital or nursing facility), time is considered the key or controlling factor to qualify for a particular level of E/M services. In general, to bill an E/M code, the physician must complete at least 2 out of 3 criteria applicable to the type/level of service provided. However, the physician must document **the total length of time of the encounter** (face to face or floor time, as appropriate), **the time spent with the patient providing counseling and/or coordination of care, and a description of the coordination of care counseling provided. Documentation must be in sufficient detail to support the claim.**

Additional Resources Available:

- NHIC, Corp. **Evaluation and Management Services Billing Guide** available at: http://www.medicarenhic.com/providers/pubs/emservicesgd.pdf Most of the information in this guide is based on Publication 100-1, Chapter 4; Publication 100-2, Chapter 7 and 15; and Publication 100-4, Chapters 1, 11 and 12 of the CMS Internet Only Manual (IOM). The CMS IOM provides detailed regulations and coverage guidelines of the Medicare program. To access the manual, visit the CMS website at http://www.cms.hhs.gov/manuals/.

- **American Medial Association CPT Coding:** http://www.amapress.org

Reference Tool:
The document on the following page is the NHIC, Corp. Evaluation & Management Coding Worksheet Tool that is used by our Nurse Reviewers and Medical Consultants when determining the level of service for adjudicating claims.

12/03/2009

Code Billed: _____ **Consult:** Yes ☐ No ☐ If yes, ALL 3 must be documented (Request ☐ Report ☐ Recommendation ☐)

Chief Complaint: _____ **Bene Initials:** _____ **D.O.S.** _____

HISTORY

HPI (history of present illness) elements:

☐ **Location** Where is problem?	☐ **Duration** Onset of .symptoms to present.	☐ **Modifying Factors** What have you done to alleviate or worsen symptoms?
☐ **Severity** How bad on a scale 1/10	☐ **Timing** When/how often	☐ **Associated Signs/Symptoms** What else is bothering you?
☐ **Quality** Sharp/dull/ hot/dry	☐ **Context** What are you doing when sxs occurs?	

Brief 1-3 **HPI** elements

Extended ≥4 **HPI** elements **or** **status of** ≥ **3** chronic or inactive conditions

ROS (Review of Systems)

☐ Constitutional	☐ Card/Vasc	☐ Musculo	☐ Psych	☐ "All Others Negative"
☐ Eyes	☐ Respiratory	☐ Integument	☐ Endo	
☐ Ears, Nose Mouth, Throat	☐ GI	☐ GU	☐ Hem/Lymph	
		☐ Neuro	☐ Allerg/Imm.	

None	1 ROS	Extended 2-9 ROS	Complete ≥ 10 ROS or some systems + statement **"all others negative"**

No PFSH is required: Subsequent Hospital and Subsequent Nursing Facility Care services require an interval history only.

☐ **Past History** (the pt's past experiences w/illnesses, operations, injuries, treatments, medications & allergies)

☐ **Family History** (review of medical events in the pt's family including diseases which are hereditary or put the pt at risk)

☐ **Social History** (an age appropriate review of past and current activities)

Established/ Subsequent ***E.D.**

New or Initial

None	1 PFSH	2 PFSH
None	1-2 PFSH	3 PFSH

Circle the entry farthest to the right for each history area. To determine history level, draw a line down the column with the circle **farthest to the left**.

Important Note: Allow a comprehensive history if the physician is ***unable*** **to obtain a history** from the patient **or other source**. The **record should describe** the patient's condition or circumstance that precludes obtaining history.
***99281-99285**: No distinction is made between **new & established** patients in the **E.D.**

PROB. FOCUSED	EXP. PROB. FOCUSED	DETAILED	COMPRE-HENSIVE
PF	EPF	D	C

EXAM

1997 Guidelines - **General Multi System**	**1997** Guidelines - **Single Organ System**	**Exam Level**
1-5 elements identified by •	**1-5** elements identified by •	**PROBLEM FOCUSED (PF)**
≥ **6** elements identified by •	≥ **6** elements identified by •	**EXPANDED PF (EPF)**
≥ **2** elements identified by • from any **6** areas/systems OR ≥**12** elements identified by • from ≥**2** areas/systems	≥ **12** elements identified by • EXCEPT ≥ **9** elements identified by • for eye & psych exams	**DETAILED (D)**
≥ **2** elements identified by • from **9** areas/systems	Document **all** elements in bolded outlined system boxes and ≥ **1** element in unbolded system boxes	**COMPREHENSIVE (C)**

Affected Body Areas (BA)	**Organ Systems (OS)**		**1995 Guidelines**			
☐ Head/Face	☐ Constitutional	☐ Skin	**1** (BA) or (OS)	**2-7** (OS) and/or (BA)	**2-7** (OS) and/or (BA)	**8** or more (OS)
☐ Neck	☐ Eyes	☐ Neuro				
☐ Abdomen	☐ Ears, nose, mouth, throat	☐ Psych	(**Limited** exam of **affected BA** or OS)	(**Limited** exam of **affected BA** or OS and other symptomatic or related OS(s))	(**Extended** exam of **affected BA(s)** and other or related OS(s))	(A **general multisystem** exam or **complete exam of a single** organ system)
☐ Chest + breast / axillae	☐ Cardiovascular	☐ Hem/Lymph/Immune				
☐ Genital/groin/buttocks	☐ Respiratory					
☐ Back, include spine	☐ GI					
☐ Extremity/(ies) **L / R** Upper	☐ GU		**PF**	**EPF**	**D**	**C**
L / R Lower	☐ Musculo					

DECISION MAKING

A Presenting Problems to the Treating Provider

(# Diags Require Active Management **or Affect Treatment Options**)

		Points = Result	
Self limited / minor (stable, improved or worse)	Max = 2	1	
Est. problem (stable, improved)	Max = 2	1	
Est. problem (worsening)	Max = 2	2	
New problem (**to Provider)** (no add'l workup)	Max=1	3	
New problem (**to Provider)** (additional workup)	Max=1	4	
Bring total to Line A in Final Result for Complexity **TOTAL**			

B Amount **and/or** Complexity of Data to be Reviewed **Pts.**

Review or order of clinical lab tests	1
Review or order of tests in the radiology section of CPT	1
Review or order of tests in the medicine section of CPT	1
Discussion of test results with performing physician	1
Decide **to obtain** old records or **to obtain** history from someone else	1
Review & summarize old records **or get Hx** from someone **or** talk with **other provider**	2
Independent visualization of image, tracing or specimen itself (not simply review of the paper copy report)	2
Bring total to Line B in Final Result for Complexity **TOTAL**	

C Risk of Complications / Morbidity / Mortality: Check off all that apply. The **highest** level of risk in any one column determines the overall risk.

Level	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
MINIMAL	• One self-limited or minor problem, *e.g., cold, insect bite, tinea corporis*	• Laboratory tests requiring venipuncture • Chest x-rays, KOH prep or EKG/EEG • Urinalysis or Ultrasound **e.g., echo** • Potassium Dydroxide prep etc.	• Rest • Gargles • Elastic bandages • Superficial dressings
LOW	• Two or more self-limited or minor problems • One stable chronic illness *e.g., well controlled hypertension, non-insulin dependent diabetes, cataract, BPH* • Acute uncomplicated illness or injury *e.g., cystitis, allergic rhinitis, simple sprain*	• Physiologic test not under stress **e.g.,** *pulm. function tests* • Non-cardiovascular imaging studies with contrast *e.g., barium enema* • Superficial needle biopsies or Skin biopsies • Clinical laboratory tests requiring arterial puncture	• Over the counter drugs • Minor surgery with no identified risk factors • Physical therapy • Occupational therapy • IV fluids without additives
MODERATE	• One or more chronic illnesses with mild exacerbation, progression or side effects of treatment • Two or more stable chronic illnesses • Undiagnosed new problem with uncertain prognosis **e.g., lump in breast** • Acute illness with systemic symptoms *e.g., pyelonephritis pneumonitis, colitis* • Acute complicated injury *e.g., head injury with brief loss of consciousness*	• Physiologic test under stress *e.g., cardiac stress test, fetal contraction stress test* • Diagnostic endoscopies with **no identified risk factors** • Deep needle or incisional biopsy • Caridovascular imaging studies with contrast and no identified risk factors *e.g., arteriogram, cardiac cath* • Obrtain fluid from body *cavity e.g., lumbar puncture, thoracentesis, culdocentesis*	• Minor surgery with identified risk factors • Elective major surgery (open percutaneous or endoscopic) with no identified risk factors) • Prescription drug management • Therapeutic nuclear medicine • IV fluids with additives • Closed treatment of fracture or dislocation without manipulation
HIGH	• One or more chronic illnesses with severe exacerbation, progression or side effects of treatment • Acute or chronic illnesses or injuries that may pose a threat to life or bodily function *e.g., multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness w/potential threat to self or others, peritonitis, acute renal failure* • An abrupt change in neurological status *e.g., seizure, TIA, weakness, sensory loss*	• Cardiovascular imaging studies with contrast with identified risk factors • Cardiac electophysiological tests • Diagnostic endoscopies with **identified risk factors** • Discography	• Elective major surgery (open, percutaneous or endoscopic) with identified risk factor • Emergency major surgery (open, percutaneous or endoscopic) • Parenteral controlled substances • Drug therapy requiring intensive monitoring for toxicity • Decision not to resuscitate or de-escalate care because of poor prognosis

A	Circle the Total number in section **A**	≤ **1** Minimal	**2** Limited	**3** Multiple	≥ **4** Extensive
B	Circle the Total number in section **B**	≤ **1** Minimal or None	**2** Limited	**3** Multiple	≥ **4** Extensive
C	Circle the Level in section **C**	Minimal	Low	Moderate	High
	Complexity Level of Medical Decision Making (Mdm)	STRAIGHTFORWARD **SF**	**LOW L**	**MODERATE M**	**HIGH H**

Draw a line down the column with 2 or 3 circles and circle decision making level OR Draw a line down the column with the center circle **=** level of **Mdm**

TIME

If the physician documents **total time** and suggests that counseling or coordinating care dominates (greater than 50%) the encounter, time may determine level of service. Documentation may refer to: prognosis, differential diagnosis, risks, benefits of treatment, instructions, compliance, and/or risk reduction.

Does documentation reveal total time?	Time: Face-to-face outpatient setting Unit/floor in inpatient setting	☐ Yes	☐ No
Does documentation describe the content of counseling or coordinating care?		☐ Yes	☐ No

If both answers are "yes," you may select the level based on time.

PLEASE NOTE: Time factors are indicated by CPT code followed by **–XX** (example: 99201-10 indicates 10 minutes)
Directions: Transfer the history, exam and medical decision making results to the correct chart below & follow the instructions for that Code family

New Office/Outpatient Visits & Office/Inpatient Consultations						Established Patient Office/Outpatient Visits				
Level	Draw a line down the column which has a key component identified which is the farthest to the left (leveled by the lowest)					If a column has 2 or 3 circles, draw a line down the column and circle the code OR draw a line down the column with the center circle and circle the code				
HX	**PF**	**EPF**	**D**	**C**	**C**	*Minimal problem that may not require presence of MD/DO*	**PF**	**EPF**	**D**	**C**
EX	**PF**	**EPF**	**D**	**C**	**C**		**PF**	**EPF**	**D**	**C**
MDM	**SF**	**SF**	**L**	**M**	**H**		**SF**	**L**	**M**	**H**
CPT Code	**99201**-10 **99241**-15 **99251**-20	**99202**-20 **99242**-30 **99252**-40	**99203**-30 **99243**-40 **99253**-55	**99204**-45 **99244**-60 **99254**-80	**99205**-60 **99245**-80 **99255**-110	**99211**-5	**99212**-10	**99213**-15	**99214**-25	**99215**-40

	Initial Hosp. Visits & Observation Care			Subsequent Hosp.		
Level	Draw a line down the column which has a key component identified which is the farthest to the left (leveled by the lowest) These are <u>PER DAY CODES</u>			If a column has 2 or 3 circles, draw a line down the column and circle the code OR draw a line down the column with the center circle and circle the code This is a <u>PER DAY CODE</u>		
HX	**D or C**	**C**	**C**	**PF interval**	**EPF interval**	**D interval**
EX	**D or C**	**C**	**C**	**PF**	**EPF**	**D**
MDM	**SF/L**	**M**	**H**	**SF/L**	**M**	**H**
CPT Code	**99221**-30 **99218** **99234**	**99222**-50 **99219** **99235**	**99223**-70 **99220** **99236**	**99231**-15	**99232**-25	**99233**-35

	EMERGENCY CARE SERVICES				
	Draw a line down the column which has a key component identified which is the farthest to the left (leveled by the lowest)				
HX	**PF**	**EPF**	**EPF**	**D**	**C**
EX	**PF**	**EPF**	**EPF**	**D**	**C**
MDM	**SF**	**L**	**M**	**M**	**H**
CPT Code	**99281**	**99282**	**99283**	**99284**	**99285**

Abbreviation Legend:

CC = Chief Complaint	**ROS = Review of System**	**PFSH = (Past, Family, Social) History**	
HX = History	**EX = Exam**	**Mdm = Medical Decision Making**	
PF = Problem Focused	**EPF = Expanded Problem Focused**	**D = Detailed**	**C = Comprehensive**
SF = Straightforward	**L = Low**	**M = Moderate**	**H = High**

Additional Comments: _____

Directions: Transfer history, exam and medical decision making results to appropriate chart below and follow the specific instructions for chart.

The Nursing Facility Care Codes are PER DAY CODES, time factors effective 2008

	Initial Nursing Facility Care			Subsequent Nursing Facility Care			
Level	Draw a line down the column which has a key component identified which is the farthest to the left (leveled by the lowest)			If a column has 2 or 3 circles, draw a line down the column and circle the code OR draw a line down the column with the center circle and circle the code			
HX	D	C	C	PF interval	EPF interval	D interval	C interval
EX	D	C	C	PF	EPF	D	C
MDM	L	M	H	SF	L	M	H
CPT Code	99304-25	99305-35	99306-45	99307-10	99308-15	99309-25	99310-35

New Patient Home/Domiciliary/Custodial/Rest Home Etc.						Established Home/Domiciliary/Custodial/Rest Home Etc.			
	Draw a line down the column which has a key component identified which is the farthest to the left (leveled by the lowest).					If a column has 2 or 3 circles, draw a line down the column and circle the code OR draw a line down the column with the center circle and circle the code			
HX	PF	EPF	D	C	C	PF interval	EPF interval	D interval	C interval
EX	PF	EPF	D	C	C	PF	EPF	D	C
MDM	SF	SF	L	M	H	SF	L	M	M to H
CPT Code	**99341**-20 **99324**-20	**99342**-30 **99325**-30	**99343**-45 **99326**-45	**99344**-60 **99327**-60	**99345**-75 **99328**-75	**99347**-15 **99334**-15	**99348**-25 **99335**-25	**99349**-40 **99336**-40	**99350**-60 **99337**-60

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Additional Comments: _____

_____