

Coding Basics and the Coding Calculator

How should I approach a note when choosing an E/M coding level?

For coding purposes, the note can be divided into three parts:

- History
- Exam
- Medical Decision Making

For **established** patients the highest level that is documented in 2 out of 3 sections, must be fulfilled when choosing a level for the visit. For **new** patients, all 3 out of 3 sections must meet the complexity level. Below is a table from the AAP coding best practices:

Key Factors that Influence E/M Coding for an Established Patient				
CPT CODE	99212	99213	99214	99215
HISTORY	Problem-focused CC Brief HPI	Expanded-problem focused CC Brief HPI Problem Pert. ROS	Detailed CC Ext. HPI Ext. ROS Pertinent PFSH	Comprehensive CC Ext. HPI Complete ROS Complete PFSH
PHYSICAL EXAM	Problem-focused	Expanded-problem focused	Detailed	Comprehensive
MEDICAL DECISION MAKING	Straightforward	Low complexity	Moderate complexity	High complexity

OP's coding calculator does the math for **established** patients. The user must be aware that new patients require 3/3 sections.

The screenshot below is an example of an established patient having sufficient documentation in the history and exam sections to meet the criteria for a comprehensive 99215 visit.

Diagnostic/Procedure Codes		Coding Decision Support	Coding Statistics
Type of visit: <input checked="" type="radio"/> Established <input type="radio"/> Inpatient <input type="radio"/> Consult <input type="radio"/> New patient <input type="radio"/> Telephone <input type="radio"/> Online		Documentation supports: 99215 Key component(s): 2 of 3 Coding count override: <input type="checkbox"/>	<input type="button" value="Apply to Visit"/> <input type="button" value="Recalculate"/>
History Documentation			
HPI elements: <input type="radio"/> 1-3 <input checked="" type="radio"/> 4 or more	ROS categories: <input type="radio"/> 1 <input type="radio"/> 2-9 <input checked="" type="radio"/> 10 or more	Sections: <input checked="" type="checkbox"/> Medical <input checked="" type="checkbox"/> Family <input checked="" type="checkbox"/> Social	History summary: <input type="radio"/> Problem Focused <input type="radio"/> Expanded Problem Focused <input type="radio"/> Detailed <input checked="" type="radio"/> Comprehensive
Exam Documentation			
Exam elements: <input type="radio"/> 1-5 <input type="radio"/> 6-11 <input type="radio"/> 12 + <input checked="" type="radio"/> 2+ on 9 systems	Vital signs measured: 3 (3 + count as 1 element)	Exam summary: <input type="radio"/> Problem Focused <input type="radio"/> Expanded Problem Focused <input type="radio"/> Detailed <input checked="" type="radio"/> Comprehensive	
Complexity of Medical Decision Making			
Diagnoses: <input checked="" type="radio"/> Minimal <input type="radio"/> Limited <input type="radio"/> Multiple <input type="radio"/> Extensive	Data review: <input checked="" type="radio"/> Minimal or none <input type="radio"/> Limited <input type="radio"/> Multiple <input type="radio"/> Extensive	Complications: <input checked="" type="radio"/> Minimal <input type="radio"/> Low <input type="radio"/> Moderate <input type="radio"/> High	MDM summary: <input checked="" type="radio"/> Straightforward <input type="radio"/> Low Complexity <input type="radio"/> Moderate Complexity <input type="radio"/> High Complexity
Counseling/Coord of Care (Time-Dominated Visit)			
<input checked="" type="radio"/> Time not a key factor. <input type="radio"/> Counseling/COC > 50% of visit		Visit length (minutes): <input type="text" value="0"/>	

Note in the above scenario, the “Complexity of Medical Decision Making” section is all at the 99212 straightforward level. This is not necessary to be higher since in an established patient, only 2/3 sections must be met. However, it is likely that in fact, this section was also higher.

Why does the Medical Decision Making (MDM) section always default to the minimal setting? Since much of the complexity of MDM is what the examining provider was thinking, there is no way to safely automate this section. The provider must document (often in the plan section) the diagnoses he made, the differential diagnoses he considered, the data he reviewed (including scanned diagnostic test documents, specialist reports, prior visits, and what the potential for complications are.

The coding calculator does not automate any of this process, always defaults to the minimal level and the provider must change these levels in the coding calculator if they believe it is integral to the coding level chosen and/or they wish the audit note to reveal this information. Remember, MDM coding support documentation is needed for all **new** patients, regardless of whether this is done in the plan section of the note, the coding calculator or both.

If the user wants the MDM level to be included in the audit note, they must choose the appropriate radio buttons for complexity (diagnoses, data review, complications) **and** check the “coding count override” box at the top of the form.

How should I handle time based coding?

When choosing an E/M level based on time, counseling or coordination of care must represent >50% of the time of the visit. It is important to note that the time bands in the grid below represent “typical” length of times for a visit at each level. The minimum time does not have to be met. If you are more than 1/2 way to the next coding level, you may “round up” and OP’s coding calculator assists you with this.

New Patient	Typical Time (minutes)	Established Patient Visit	Typical Time (minutes)
99201	10	99211	5
99202	20	99212	10
99203	30	99213	15
99204	45	99214	25
99205	60	99215	40

Additional guidance/examples on rounding rules can be found here:

When Time Spent Falls Between Two Typical Times

If the total time of a visit falls in between two reference codes (eg, a 20 minute visit, which falls just halfway between a 99213 [15 minutes] and a 99214 [25 minutes]), you need to determine if the time spent is closer to the lesser time [eg, 15 minutes] or the longer time [eg, 25 minutes]. If the time spent is closer to the lower typical time report the code with the lower time. If the time spent is closer to the higher typical time, report the code with the higher typical time.

Example: Physician spends 20 minutes with an established patient and parent. 15 minutes are spent in counseling/coordination of care. Since 20 minutes falls directly in between a 99213 [15 mins] and 99214 [20 mins], what do you report?

- 99213 – When the time spent is exactly the mid-point between 2 codes, you round down.
Example: Physician spends 40 minutes with a new patient. Of that time over 30 minutes is spent in counseling/coordination of care. Since 40 minutes falls in between a 99203 [30 mins] and a 99204 [45 mins], what do you report?
- 99204 – Because the typical time mid-point was passed [ie, 38 mins] you can round-up to the higher code.
Example: Physician spends 30 minutes with an established patient and parent. The entire visit is spent in counseling/coordination of care. Since 30 minutes falls in between a 99214 [25 mins] and 99215 [40 mins], what do you report?
- 99214 – Even though you went over the typical time required for code 99214, you did not pass the mid-point therefore you round down.

Caveat: The above guidelines for reporting when time spent falls between two typical times is a CPT guideline. Some Medicaid payers may differ.

Caveat: If you perform counseling/coordination of care for greater than 50% of a visit yet the total visit time does not meet the typical time requirement of even the lowest level code, you cannot use time as your key factor.

How do I document time spent?

There are 2 fields which should contain time to support choosing a coding level based on time. First, it is important to document the time spent counseling **or** coordinating care in the appropriate visit tab and to check the radio button that says this was >50% of the visit:

Counseling: Spent 20 minutes face to face with patient then patient and parents discussing depression/anxiety, treatment plan and follow-up

Time spent: 20 ☒ Key factor: Counseling >50% of visit time ☐ NOT key factor

Visibility: Any staff member

Coordination of care:

Time spent: 0 ☐ Key factor: Coord of care >50% of visit time ☐ NOT key factor

Secondly, the user should document the length of the entire visit on the coding calculator. This ensures that both the total counseling/coordination of care time and the total visit time will display in the audit note and will meet the documentation standards during an audit.

Diagnostic/Procedure Codes Coding Decision Support Coding Statistics

Type of visit:
☒ Established ☐ Inpatient ☐ Consult
☐ New patient ☐ Telephone ☐ Online

Documentation supports: 99214
 Key component(s): Time
 Coding count override: ☐

Apply Recalc

History Documentation

HPI elements:
☒ 1-3 ☐ 4 or more

ROS categories:
☐ 1 ☒ 2-9 ☐ 10 or more

Pert sections:
☐ Medical ☐ Family ☐ Social

History summary:
☐ Problem Focused ☒ Expanded Problem Focused ☐ Detailed ☐ Comprehensive

Exam Documentation

Exam elements:
☐ 1-5 ☐ 6-11 ☒ 12+ ☐ 2+ on 9 systems

Vital signs measured: 0
 (3+ count as 1 element)

Exam summary:
☐ Problem Focused ☐ Expanded Problem Focused ☒ Detailed ☐ Comprehensive

Complexity of Medical Decision Making

Diagnoses:
☒ Minimal ☐ Limited ☐ Multiple ☐ Extensive

Data review:
☒ Minimal or none ☐ Limited ☐ Multiple ☐ Extensive

Complications:
☒ Minimal ☐ Low ☐ Moderate ☐ High

MDM summary:
☒ Straightforward ☐ Low Complexity ☐ Moderate Complexity ☐ High Complexity

Counseling/Coordination of Care (Time-Dominated Visit)

☐ Time not a key factor. ☒ Counseling/COC > 50% of visit

Visit length (minutes): 30

Many users repeat this information in the body of the plan of their note so there can be no room for misinterpretation. (Remember in the eyes of the audit reviewer/payer: "If it wasn't documented, it wasn't done.")

Diagnoses:	ICD-10 Description	ICD-10	SNOMED Description
Click here to add a new diagnosis			
Adjustment disorder with depressed mood	F43.21		Adjustment disorder with mixed emotional features

Assessment:

☒ Plan: Discussed diagnosis/concerns with patient/family
☐ Patient instruct: Spent 20 minutes face to face with patient then patient & family counseling regarding issues related to anxiety/depression out of total 30 minute visit.
☐ Discussed legal implications/regulations of confidentiality for mental health concerns if appropriate
☐ No suicidal thoughts or ideations at present but discussed need for continued closed observation and how/where to seek emergent help if indicated
☐ Discussed consideration to psychologist/counselor involvement and appropriate referrals made if indicated
☐ Discussed when/if referral to psychiatrist is warranted and appropriate referrals made if indicated
☐ Disc considerations to appropriate therapies including counseling and medication

References:

[Coding at the AAP](#)

CMS [Outreach Education for E/M Coding](#)

AAP: [Time is of the Essence: Coding on the Basis of Time for Physician Services](#)

Additional AAP Resources:

Coding Resources

View a collection of resources to assist with practice implementation.



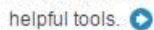
Coding Fact Sheets and Billing Position Papers

View a collection of topic-specific fact sheets.



CPT and Modifiers

Find a variety of coding guidelines and other helpful tools.



Evaluation and Management (E/M)

Find important related-resources.



Vaccine Coding

Learn about the coding resources available for managing vaccines in practice.

