How To Avoid Coding Errors

R. Bruce Cameron, M.D., FACG
ACG Governors Best Practices Course
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General Rules

• Buy a current CPT book
• Buy a current ASGE coding book
• Send your office manager/billing person to a Coding seminar
• Code for what you do and only what you do
• Don’t think you won’t get caught if you cheat
Coding Documentation

• Not emphasized in training programs
• Often use different definitions from those commonly used in the clinical setting
• Specific phrases not used in clinical care are often necessary to capture Coding documentation requirements
• Not intuitive to physicians

Coding Documentation

• Documentation for Coding services must reflect services performed and that are medically necessary
• Obtaining history or performing components of exam that are unrelated to the patient’s condition is not acceptable to meet a certain Coding level
Common Coding and Billing Mistakes

- Be cautious with EMR software that automatically up-codes by inserting default negative ROS or PE that was not actually performed or un-bundles codes inappropriately (surgical includes diagnostic)
- Down Coding or under-coding leaves money on the table
- Never use the “approximate” code; if the code does not exist use the unlisted code with a letter of explanation

Common Errors

- New patient vs. Established patient
- Place of Service
- Pre op visit for screening colonoscopy
- Screening vs. Diagnostic Colonoscopy
- Modifiers
- Extensive CPT changes for 2014
- E+M Coding
New vs. Established

- A “new” patient is one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice within the past three years.
- An “established” patient has received services from the physician or another physician of the same specialty who belongs to the same group practice within the past three years.
- No distinction is made in the emergency room.

Place of Service Codes

- 11- Office
- 12- Home
- 13- Assisted Living Facility
- 20- Urgent Care Facility
- 21- Inpatient Hospital
- 22- Outpatient Hospital
- 23- Emergency Room-Hospital
- 24- Ambulatory Surgery Center
Pre Op Visit for Screening Colonoscopy

- Brief endoscopy unit H&P before procedure is included in the procedure value as thought to be “incident to” the procedure
- For a significant E+M service on the same day as a procedure, a ‘25’ modifier should be appended to the E+M service
- A Pre Op Visit on a separate day must document management of a co-morbid illness (anticoagulant or insulin) to be separately billed

Screening vs. Diagnostic

- Screening defined as lack of Symptoms or abnormalities
- Average risk patient, age 50, every 10 years (119 months for Medicare)
- High risk patient, age 40 or 10 years prior to index family member-every 2-5 years (23 months)
  - First degree relative or personal history of Adenomatous polyp or Cancer
  - Inflammatory bowel disease
- Commercial payers may consider 2 second degree relatives
Screening vs. Diagnostic

• If a polyp or lesion is found during a screening procedure and an action is taken it becomes a therapeutic/diagnostic procedure
• Bill with ‘screening’ as the first diagnostic code (ICD-9) and the finding as the secondary code
• Medicare add PT modifier to the CPT code
• Commercial payers add modifier 33

CPT Codes

• GI Procedure Code Families
  – Esophagus 43200-43232
  – EGD 43234-43259
  – Lower GI 46600-45392
  – ERCP 43260-43273
  – Small Bowel 44360-44397
Therapeutic Colonoscopy

- Therapeutic endoscopy codes always include the diagnostic code (base code) - “surgical includes diagnostic”
- Codes within families can be billed together using a '59' modifier if different lesions are treated by different methods
- Multiple therapies on the same lesion should be billed with one code (the more complex service)
- Multiple lesions treated in the same manner should be billed with only one code

A biopsy forceps is not a snare therefore removing a polyp with a cold biopsy forceps is coded 45380, colonoscopy with biopsy
- 45380, 45383, 45384, and 45385 can be billed together if they are used on separate and distinct lesions or areas in the colon, use modifier -59
- Overuse will trigger audit
- Do not use 45382 (control of bleeding) if you start the bleeding as a result of a therapeutic intervention
Modifiers

- **Modifier 51** – used with 2 procedures of different families on the same day
  - (EGD + colonoscopy)
- Medicare automatically adds this code
- Multiple procedure rule applies
  - 50% for second procedure
  - 25% for third procedure
- **List greatest valued code first**

Modifiers

- **Modifier 59** – use for 2 procedures within the same family
  - 45385 - Colonoscopy and polypectomy and 
    45380-59 - Colonoscopy and biopsy
- Payment for second procedure is difference between the modified code and the base code
  - 45380 minus 45378 = payment for biopsy
- **List code with greatest value first**
Modifiers

- **Modifier 25** – significant separately identifiable E+M service on day of procedure
- Beyond the usual pre-and post operative care ‘incident to’ procedure
- Append to the E+M code
- Do not use modifier 57 - decision for surgery on same day as procedure (for procedures with 10 and 90 day Global periods)

Modifiers

- **Modifier 33** – applies to **commercial** lines of business only
- Applies to preventive services that do not have a unique code indicating prevention
  - Flexible sigmoidoscopy and colonoscopy codes
- Used when service initiated as preventive is converted to therapeutic (45378 changes to 45385-33)
- In full force by 2014 for grandfathered policies, or as current plans renew or change
Modifiers

• **Modifier PT** - applies to Medicare products only including Medicare advantage and Medicare supplemental

• Screening colorectal exam converts to diagnostic service
  – (G0121 + G0105 convert to 45385-PT)

• Do not use when service began as diagnostic procedure

• Medicare deductible is waived but Co-Pay still applies (flaw in Medicare law)

Modifiers

• Incomplete colonoscopy due to “unforeseen circumstances” (poor prep)

• **Medicare** modifier 53 - discontinued procedure

• **Commercial payers** modifier 52-reduced service

• Consider using modifier 53 even if past the splenic flexure to preserve Medicare screening benefit for later complete exam
Modifiers

• Modifier 78 = unplanned return to procedure room during postoperative period (for different procedure latter the same day)

• If the same procedure is done latter the same day use modifier 76 (same physician) or 77 (different physician)

Modifiers

• HOPD/ASC facility charge reporting for canceled procedure as a result of extenuating circumstances or that threaten the patient (not elective cancellation)

• **Modifier 73** -discontinued HOPD/ASC procedure prior to anesthesia

• **Modifier 74** -discontinued HOPD/ASC procedure after administration of anesthesia
Modifiers

- **Modifier 22** – increased procedural services
- Must submit procedure report that makes the increased service clear with letter
- May get additional 25% after one or 2 appeals

CPT Changes 2014

**Esophagoscopy**

**New definition**

- Esophagoscopy includes examination from the cricopharyngeus muscle (upper esophageal sphincter) to and including the gastroesophageal junction. It may also include examination of the proximal region of the stomach via retroflexion when performed.
CPT Changes 2014
Esophagoscopy

Deleted Codes

• 43219 insertion of stent (use 43212)
• 43228 ablation of tumor (use 43229)
• 43234 EGD primary exam with small diameter endoscope

New Codes

• 43211 Mucosal resection

• 43212 placement of stent (includes pre-post dilatation and guidewire)

• 432213 dilatation by balloon-retrograde (includes fluoroscopy)
CPT Changes 2014

Esophagoscopy

New Codes

• 43214 Balloon dilatation >30 mm (includes Fluoroscopy)

• 43229 Ablation of tumor (includes pre-post balloon dilatation and guidewire)

CPT Changes 2014

EGD

New reduced service instruction

• To report EGD where the duodenum is deliberately not examined (e.g., judged clinically not pertinent), or because significant situations preclude such exam (e.g., significant gastric retention precludes safe exam of duodenum), append modifier 52 if repeat examination is not planned, or modifier 53 if repeat examination is planned
Deleted codes

• 43256 Stent placement (use 43266)

• 43258 Ablation of tumor (use 43270)

New Codes

• 43233 Balloon dilatation >30 mm (includes Fluoroscopy)

• 43253 Ultrasound guided injection

• 43254 Endoscopic mucosal resection-any method (Includes injection, banding, snare)
**CPT Changes 2014**

**EGD**

**New codes**

- 43266 Placement of stent (includes guidewire, dilatation, cyst drainage)
- 43270 Ablation of tumor (includes pre-post dilatation and guidewire)

**CPT Changes 2014**

**ERCP**

**Deleted codes**

- 43267 Naso Biliary/Pancreatic drain (use 43274)
- 43268 Biliary/Pancreatic tube insertion (use 43274)
- 43269 Removal of Stent/Foreign body (use 43275/43276)
CPT Changes 2014
ERCP

Deleted codes

• 43271 Balloon dilatation (use 43277)

• 43272 Ablation of tumor (use 43278)

CPT Changes 2014
ERCP

New Codes

• 43274 Placement of stent (Includes sphincterotomy, stent removal, stent exchange, balloon dilatation)
  – May submit charges for 3 separate stints (right and left hepatic ducts and pancreatic duct) or two side-by-side stints in the same duct by using modifier 59
CPT Changes 2014
ERCP

New Codes

• 43275 Removal of foreign body/stent

• 43276 Removal and exchange of stent
  (Includes pre-/post dilatation, sphincterotomy and guide wire)
  – May submit charges for separate stints removed and exchanged by using modifier 59

• 43277 Balloon dilatation of biliary/pancreatic duct or ampulla (includes sphincterotomy)
  – May submit charges for each separate duct using modifier 59

• 43278 Ablation of tumor (Includes pre-/post dilatation and guide wire)
CPT Changes 2014

• 91065 Breath hydrogen methane test
• Code revised to state: breath hydrogen or methane test (e.g., for detection of lactase deficiency, fructose intolerance, bacterial overgrowth, or Oro-cecal gastrointestinal transit)
  – Report once whether one or both analytes are reported. The code can be reported separately for each administered challenge (e.g. lactose, fructose, etc)

E/M Codes

• There are seven components to the descriptor of all E/M services
  – History
  – Examination
  – Medical Decision Making
  – Counseling
  – Coordination of Care
  – Nature of Presenting Problem
  – Time
General Rules

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Colonoscopy through Stoma

- **44388**-Colonoscopy through stoma
- Evaluation of the rectum/sigmoid should not be separately billed
R. Bruce Cameron, MD, FACG, FASGE

Retrograde Double Balloon

- Retrograde enteroscopy beyond 50 cm of ileum should be coded 44799- un-listed code with a letter and report
- It should be reported with a standard colonoscopy code and a modifier 59
  - 44799, 45378-59
- Document the extra time spent in the small bowel on report and letter

Hemorrhoids

- **46221** hemorrhoidectomy by simple ligature (rubber band) is **10-day global**
- 46930-destruction of internal hemorrhoids by thermal energy is **90 day Global**
- 46945- ligation of internal hemorrhoids is surgical procedure with **90 day Global** with anesthesia included
PEG Tube Removal

- Percutaneous removal of a PEG tube at the bedside or office without anesthesia is billed using the visit E+M code

Large-Volume Paracentesis

- Use 49080 – initial or 49081 subsequent
- Do not use 49420 insertion of a peritoneal catheter for drainage or dialysis-temporary even for large volume paracentesis
**Enteroscopy and PEJ**

- **44372**-enteroscopy and PEJ may be reported by 2 surgeons using modifier 62
- Each get 62.5% of the usual fee =125%
- No payment until both claims received
- Medicare will not pay if both physicians are of the same specialty

**CPT / E+M Coding**

- Evaluation and management codes are the codes used to report patient interactions at office visits, hospital visits, and consultations.
- Value increasing relative to procedures
- E/M codes are further divided into subcategories for new or established patients.
- The subcategories of E/M Codes are further classified into levels of service depending on the nature of total physician work.
Consultation Codes

- 95% of 99245 and 99255 consultation codes are incorrectly/insufficiently documented
- 45% of all consult codes are miscoded
- Cost to Medicare = $1.1 billion
- Past Medical History, Review of Systems, Family History, lack of Consult Request and missing Consult Report are most common deficient areas
- Therefore CMS eliminated consult codes

CPT code ‘Office Consultation’
(opinion or advice requested by another physician or appropriate source)

<table>
<thead>
<tr>
<th>History</th>
<th>Examination</th>
<th>Decision making</th>
</tr>
</thead>
<tbody>
<tr>
<td>99241 15 minutes</td>
<td>Problem focused</td>
<td>Problem focused</td>
</tr>
<tr>
<td>99242 30 minutes</td>
<td>expanded</td>
<td>expanded</td>
</tr>
<tr>
<td>99243 40 minutes</td>
<td>detailed</td>
<td>detailed</td>
</tr>
<tr>
<td>99244 60 minutes</td>
<td>comprehensive</td>
<td>comprehensive</td>
</tr>
<tr>
<td>99245 80 minutes</td>
<td>comprehensive</td>
<td>comprehensive</td>
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</tbody>
</table>

NO MEDICARE!
<table>
<thead>
<tr>
<th>E/M codes</th>
<th>CPT Definition of Organ Systems</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Eyes</td>
<td>• Musculoskeletal</td>
</tr>
<tr>
<td>• Ears, nose, mouth, and throat</td>
<td>• Skin/breast</td>
</tr>
<tr>
<td>• Cardiovascular</td>
<td>• Endocrine</td>
</tr>
<tr>
<td>• Respiratory</td>
<td>• Neurological</td>
</tr>
<tr>
<td>• Gastrointestinal</td>
<td>• Psychiatric</td>
</tr>
<tr>
<td>• Genitourinary</td>
<td>• Hematologic / lymphatic</td>
</tr>
<tr>
<td>• Allergy/immunology</td>
<td>• Constitutional</td>
</tr>
</tbody>
</table>

### Organ System

- **Gastrointestinal**
  - Examination of abdomen with notation of presence or absence of masses or tenderness
  - Examination of liver and spleen
  - Examination for presence or absence of hernia
  - Examination of anus, perineum, and rectum (sphincter tone, hemorrhoids, rectal mass)
  - Stool for occult blood
### E/M codes

#### Extent of History Obtained

<table>
<thead>
<tr>
<th>Problem focused</th>
<th>Expanded problem focused</th>
<th>Detailed</th>
<th>Comprehensive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief complaint</td>
<td>Chief complaint</td>
<td>Chief complaint</td>
<td>Chief complaint</td>
</tr>
<tr>
<td>Brief history of present illness (1-3 elements)</td>
<td>Brief history of present illness (1-3 elements)</td>
<td>Extended history of present illness (4 or more elements)</td>
<td>Extended history of present illness (4 or more elements)</td>
</tr>
<tr>
<td>(duration, location, severity, context, quality, timing, associated signs, modifying)</td>
<td>Problem pertinent system review (2-9 organ systems)</td>
<td>Problem pertinent system review (2-9 organ systems)</td>
<td>Complete review of systems (10 organ systems)</td>
</tr>
<tr>
<td>Pertinent past, family, social history</td>
<td>Complete past, family, social history</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Extent of Examination Performed

- **Problem focused**: Limited examination of the affected body area or organ system (1-5 elements)
- **Expanded**: problem focused: a limited examination of the affected body area and other symptomatic or related organ systems (at least six elements in one or more organ systems or body areas)
- **Detailed**: an extended examination of the affected body area and other symptomatic or related organ systems (at least six organ systems or body areas, 2 elements per system/area or 12 elements in two or more organ systems)
- **Comprehensive**: a general multisystem examination or a complete examination of a single organ system (at least nine organ systems / areas each with two elements)
E/M Codes - Complexity of Medical Decision Making

- **Number** of possible diagnoses and/or management options
- Amount and/or **complexity** of medical records, diagnostic tests, or other information that must be obtained reviewed and analyzed
- **Risk** of significant complications, morbidity, and mortality associated with the presenting problem or the **diagnostic procedure** or possible management options

### Complexity of Medical Decision Making
(Two of the Three Key Components)

<table>
<thead>
<tr>
<th>Number of diagnoses or management options</th>
<th>Amount and/or complexity of data to be reviewed</th>
<th>Risk of complications and/or morbidity or mortality</th>
<th>Type of decision making</th>
</tr>
</thead>
<tbody>
<tr>
<td>minimal</td>
<td>Minimal or none</td>
<td>minimal</td>
<td>straightforward</td>
</tr>
<tr>
<td>limited</td>
<td>limited</td>
<td>low</td>
<td>Low complexity</td>
</tr>
<tr>
<td>multiple</td>
<td>moderate</td>
<td>moderate</td>
<td><strong>Moderate complexity</strong></td>
</tr>
<tr>
<td>extensive</td>
<td>extensive</td>
<td>high</td>
<td>High complexity</td>
</tr>
</tbody>
</table>
**Number** of diagnosis or management options

- **Minimal** = One new or chronic self-limiting problem
- **Limited** = Two or more new / chronic minor problems
- **Multiple** = Presenting/established problems inadequately controlled or failing therapy
- **Extensive** = One or more new problems requiring additional workup

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**Amount/Complexity** of Data

- Ordered, reviewed, or called for...
  - Clinical lab test
  - Radiology
  - Diagnostic test
  - Discussed test results with performing or interpreting physician
  - Request old records
  - Personally review image, tracing, or specimen previously interpreted by another physician
  - Review a dictated summary, old record, or history from other source than patient (must be documented in chart) (worth 'limited' by itself)*

- **Minimal** = 1, **limited** = 2, **moderate** = 3, **extensive** = 4
**Risk Assessment**

- **Minimal** = one self limited problem, evaluated with blood test, chest x-ray, EKG, UA, ultrasound, and treated with rest and over-the-counter meds
- **Low** = two or more minor problems/one stable chronic illness (hypertension, AODM), evaluated with superficial biopsy, arterial puncture, non-stress physiologic test, contrast imaging

- **Moderate** = one or more chronic illnesses with mild exacerbations, progression, or side effect of treatment, 2 stable chronic illness, undiagnosed new problem with uncertain prognosis, acute illness (pneumonia), evaluated with physiologic tests under stress, **endoscopy with low risk**, deep biopsy, cardiovascular contrast study, body cavity fluid aspiration, treated with elective or minor surgery, **prescription drugs**, IV fluids with additives
Risk Assessment

- **High** = chronic illness with exacerbation, progression, or side effect of treatment, life-threatening illness or injury (GI bleeding), acute change in mental status, evaluated by endoscopy with identified risk factors, cardiac electrophysiologic tests, cardiac cath with risk factors, and treated with elective or emergency major surgery, controlled substances, drug therapy requiring monitoring for toxicity (immunosuppressant), DNR

<table>
<thead>
<tr>
<th>Complexity of Medical Decision Making (Two of the Three Key Components)</th>
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<tbody>
<tr>
<td><strong>Number of diagnoses or management options</strong></td>
</tr>
<tr>
<td>Minimal (1)</td>
</tr>
<tr>
<td>Limited (2)</td>
</tr>
<tr>
<td>Multiple (Poorly Controlled)</td>
</tr>
<tr>
<td>Extensive (New Requiring W/U)</td>
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### CPT code new patient - office

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Time (minutes)</th>
<th>History</th>
<th>Examination</th>
<th>Decision making</th>
</tr>
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<tbody>
<tr>
<td>99201</td>
<td>10</td>
<td>Problem focused</td>
<td>Problem focused</td>
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</tr>
<tr>
<td>99202</td>
<td>20</td>
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<td>straightforward</td>
</tr>
<tr>
<td>99203</td>
<td>30</td>
<td>detailed</td>
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<td>Low complexity</td>
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<tr>
<td>99204</td>
<td>45</td>
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<td>Moderate complexity</td>
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<tr>
<td>99205</td>
<td>60</td>
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<td>High complexity</td>
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</table>

3 of 3 Components

### CPT code established patient - office

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Time (minutes)</th>
<th>History</th>
<th>Examination</th>
<th>Decision making</th>
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<tbody>
<tr>
<td>99211</td>
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<td>minimal</td>
<td>minimal</td>
<td>minimal</td>
</tr>
<tr>
<td>99212</td>
<td>10</td>
<td>Problem focused</td>
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<tr>
<td>99213</td>
<td>15</td>
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<tr>
<td>99214</td>
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## CPT code ‘Inpatient Consultation’
(opinion or advice requested by another physician or appropriate source)

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<thead>
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<th>Code</th>
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<th>Decision making</th>
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<tr>
<td>99252</td>
<td>40</td>
<td>expanded</td>
<td>expanded</td>
<td>straightforward</td>
</tr>
<tr>
<td>99253</td>
<td>55</td>
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<td>detailed</td>
<td>Low complexity</td>
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<tr>
<td>99254</td>
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<td>99255</td>
<td>110</td>
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<td>comprehensive</td>
<td>High complexity</td>
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</tbody>
</table>

*NO MEDICARE!*

## CPT code ‘Office Consultation’
(opinion or advice requested by another physician or appropriate source)

<table>
<thead>
<tr>
<th>Code</th>
<th>Minutes</th>
<th>History</th>
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<th>Decision making</th>
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<tbody>
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<td>Problem focused</td>
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<tr>
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<td>straightforward</td>
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<tr>
<td>99243</td>
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<td>detailed</td>
<td>Low complexity</td>
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<td>comprehensive</td>
<td>High complexity</td>
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*NO MEDICARE!*
### CPT CODE

#### Initial Hospital Care

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Time on Unit</th>
<th>History</th>
<th>Examination</th>
<th>Decision Making</th>
</tr>
</thead>
<tbody>
<tr>
<td>99221</td>
<td>30 min</td>
<td>Detailed</td>
<td>Detailed</td>
<td>Straight-forward</td>
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<tr>
<td>99222</td>
<td>50 min</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
<td>Moderate</td>
</tr>
<tr>
<td>99223</td>
<td>70 min</td>
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<td>Comprehensive</td>
<td>High Complexity</td>
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</table>

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#### Subsequent Hospital Care

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Time on Unit</th>
<th>History</th>
<th>Examination</th>
<th>Decision Making</th>
</tr>
</thead>
<tbody>
<tr>
<td>99231</td>
<td>15 min</td>
<td>Problem Focused</td>
<td>Problem Focused</td>
<td>Straight-Forward</td>
</tr>
<tr>
<td>99232</td>
<td>25 min</td>
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<td>Expanded</td>
<td>Moderate</td>
</tr>
<tr>
<td>99233</td>
<td>35 min</td>
<td>Detailed</td>
<td>Detailed</td>
<td>High Complexity</td>
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2 of 3 Components
## Initial Observation Hospital Care

Stay does not extend across 2 midnights

<table>
<thead>
<tr>
<th>CPT CODE</th>
<th>History</th>
<th>Examination</th>
<th>Decision Making</th>
</tr>
</thead>
<tbody>
<tr>
<td>99218</td>
<td>Detailed</td>
<td>Detailed</td>
<td>Straight Forward</td>
</tr>
<tr>
<td>99219</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
<td>Moderate Complexity</td>
</tr>
<tr>
<td>99220</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
<td>High Complexity</td>
</tr>
</tbody>
</table>

## Subsequent Observation Hospital Care

Stay does not extend across 2 midnights

<table>
<thead>
<tr>
<th>CPT CODE</th>
<th>History</th>
<th>Examination</th>
<th>Decision Making</th>
</tr>
</thead>
<tbody>
<tr>
<td>99224</td>
<td>Problem Focused</td>
<td>Problem Focused</td>
<td>Straight-Forward</td>
</tr>
<tr>
<td>99225</td>
<td>Expanded</td>
<td>Expanded</td>
<td>Moderate</td>
</tr>
<tr>
<td>99226</td>
<td>Detailed</td>
<td>Detailed</td>
<td>High Complexity</td>
</tr>
</tbody>
</table>

2 of 3 Components
Evaluation and Management Code

- Do not use “unremarkable”, “negative”, “noncontributory”, or “normal”
- Document negative responses or “past, family, and social history obtained but not pertinent to current problem” or “all systems have been reviewed and are negative except as previously noted”

Evaluation and Management Code

- List of severity (i.e., asthma with severe exacerbation)
- List co-morbid conditions
- Document review of report vs. independent visualization of raw data (x-ray itself reviewed vs. only report)