Health Partners Plans ICD-10 Coding Guide

Health Partners Plans HPP

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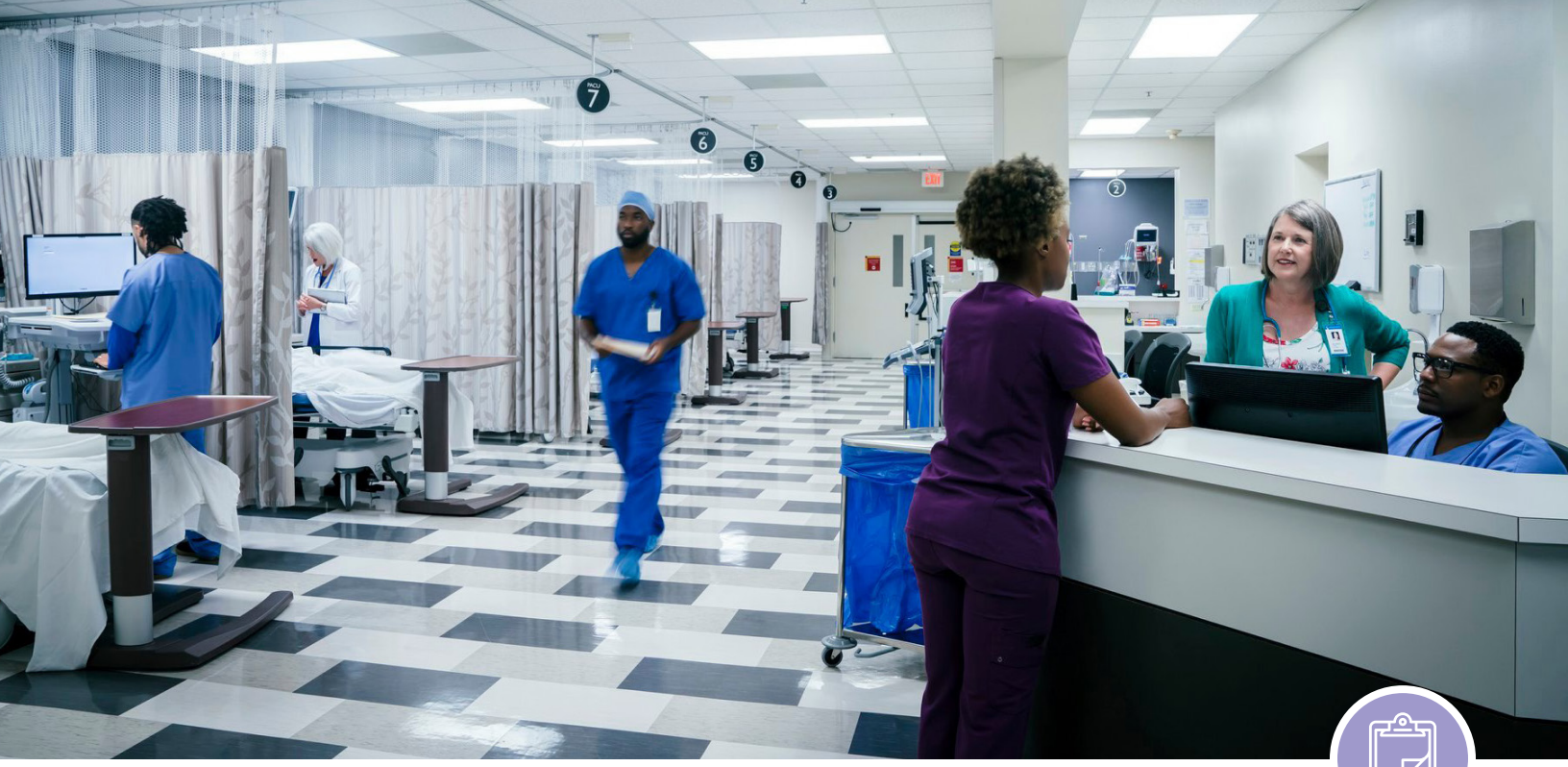

The codes listed are ICD-10 diagnosis codes that are most commonly used and billed for by providers but lack specificity. Use this guide to further specify the condition of the member. Medical record documentation should accurately match the diagnosis codes being billed for.

For more coding information, please contact Christina Rock, Supervisor, Clinical Education, at **crock@hpplans.com**.

Asthma

Mild		Modereate	Severe
Intermittent, uncomplicated/ NOS **J45.20**	Persistent, uncomplicated/ NOS **J45.30**	Persistent, uncomplicated/ NOS **J45.40**	Persistent, uncomplicated/ NOS **J45.50**
Intermittent, with acute exacerbation **J45.21**	Persistent, with acute exacerbation **J45.31**	Persistent, with acute exacerbation **J45.41**	Persistent, with acute exacerbation **J45.51**
Intermittent, with status asthmatics **J45.22**	Persistent, with status asthmatics **J45.32**	Persistent, with status asthmatics **J45.42**	Persistent, with status asthmatics **J45.52**

When documenting asthma, include the following:

1. Cause – Exercise induced, cough variant, related to smoking, chemical or particulate cause, occupational

2. Severity – Choose one of the three: mild, moderate or severe

3. Temporal Factors – Acute, chronic, intermittent, persistent, status asthmatics, acute exacerbation

Type II Diabetes Mellitus E11

Type II with Kidney Complications E11.2 *Use additional code to identify stage of CKD	
Type II diabetes mellitus with diabetic nephropathy **E11.21**	Type II diabetes mellitus with diabetic chronic kidney disease (CKD) **E11.22**

Type II with Ophthalmic Complications E11.3	
Non-Proliferative Retinopathy	Proliferative Retinopathy
Mild Non-Proliferative Retinopathy E11.32	Type II diabetes mellitus with proliferative diabetic retinopathy E11.35
Moderate Non-Proliferative Retinopathy E11.33	
Severe Non-Proliferative Retinopathy E11.34	

Type II with Neurological Complications E11.4
Type II diabetes mellitus with diabetic mononeuropathy **E11.41**
Type II diabetes mellitus with diabetic polyneuropathy **E11.42**
Type II diabetes mellitus with diabetic autonomic (poly) neuropathy **E11.43**

Add 4th – 7th digits

- **When documenting diabetes, include the following:**

1. Type (e.g., Type I or Type II), drug or chemical induced, due to underlying condition
2. Complications (e.g., foot ulcers, retinopathy, neuropathy)
3. Treatment (e.g., insulin)

- **Use Z13.1 for screening of diabetes mellitus or signs and symptoms codes until diagnosis is confirmed**

Chronic Kidney Disease (CKD)

Stage 1 Normal GFR (≥ 90 mL/min/1.73 m2) plus either persistent albuminuria or known structural or hereditary renal disease	**N18.1**
Stage 2 GFR 60 to 89 mL/min/1.73 m2	**N18.2**
Stage 3 GFR 30 to 59 m./min/1.73m2	**N18.30**
Stage 3a GFR 45 to 59 mL/min/1.73 m2	**N18.31**
Stage 3b GFR 30 to 44 mL/min/1.73 m2	**N18.32**
Stage 4 GFR 15 to 29 mL/min/1.73 m2	**N18.4**
Stage 5 GFR < 15 mL/min/1.73 m2	**N18.5**
End Stage Chronic kidney disease requiring chronic dialysis	**N18.6**

When coding for CKD, code first any:

- Diabetic chronic kidney disease
- Hypertensive chronic kidney disease
- Use additional code to identify dialysis status Z99.2

Hypertension Diseases

- **Essential (Primary)** I10
- **Primary Pulmonary** I27
- **Hypertensive Heart** I11
- **Hypertensive Chronic Kidney Disease**
  - Hypertensive chronic kidney disease with stage 5 chronic kidney disease or end-stage renal disease **I12.0**
  - Hypertensive chronic kidney disease with stage 1–4 chronic kidney disease, or unspecified kidney disease **I12.9**
- **Hypertensive Heart and Chronic Kidney Disease**
  - Hypertensive heart and chronic kidney disease with heart failure and stage 1–4 chronic kidney disease, or unspecified chronic kidney disease **I13.0**
  - Hypertensive heart and chronic kidney disease without heart failure with stage 1–4 chronic kidney disease **I13.10**
  - Hypertensive heart and chronic kidney disease without heart failure with stage 5 or end-stage renal disease **I13.11**
  - Hypertensive heart and chronic kidney disease with heart failure and with stage 5 or end-stage renal disease **I13.2**

Add 4th – 7th digits 3 Digit Reportable

When documenting hypertension, include the following:

1. Type (e.g., essential, secondary)
2. Causal relationship (e.g., renal, pulmonary)
3. Use additional codes to identify:
   a. Type of heart failure
   b. Stage of chronic kidney disease

Atrial Fibrillation

Persistent	Chronic	Other
Longstanding persistent atrial fibrillation **I48.11**	Chronic atrial fibrillation, unspecified **I48.20**	Paroxysmal atrial fibrillation **I48.0**
Other persistent atrial fibrillation **I48.19**	Permanent atrial fibrillation **I48.21**	Unspecified atrial fibrillation **I48.91**

When documenting atrial fibrillation, include the following:

- Atrial fibrillation is still reported in patients that are not currently experiencing the erratic rhythm as long as the patient is requiring ongoing medication to help control the rate.
- Atrial fibrillation is very common in postoperative patients and should be verified as a complication before coding as such.
- When multiple types of atrial fibrillation are documented in the record, select the most specific type.

Coronavirus Infection (COVID-19)

Confirmed diagnosis of COVID-19 Positive COVID-19 test or "presumptive" positive COVID-19 test	**U07.1**
Contact with and suspected exposure to COVID-19 Asymptomatic or symptomatic (code symptoms)	**Z20.822**
Suspected possible COVID-19 exposure ruled out Code symptoms if patient symptomatic	**Z03.818**
Encounter for screening for COVID-19 During the COVID-19 pandemic, a screening code is generally not appropriate.	**Z11.52**
Personal history of COVID-19	**Z86.16**
Follow-up visit after COVID-19 infection resolved	**Z09**

When coding for Covid-19:

- Code U07.1 as principle dx when it meets criteria; code any associating manifestations(e.g. pneumonia, ARDS).
- Certain codes need to be sequenced first, such as obstetrics, sepsis, or transplant complications.
- Code sign(s) and symptom(s) until definitive diagnosis(es) is confirmed.
- U07.2 is not a valid code for ICD-10-CM in the United States.

Other Conditions: Adult & Pediatric Codes (A–E)

- **Certain Infectious & Parasitic Disease (A00-B99)**
  - Viral hepatitis **B15-19**
  - Human immunodeficiency virus disease **B20**
- **Disease of the Blood & Blood-Forming Organs (D50-D89)**
  - Anemia due to G6PD Deficiency (Pediatric) **D55.0**
  - Alpha thalassemia **D56.0**
  - Hb – SS Disease with crisis **D57.0**
  - Hb – SS Disease without crisis **D57.1**
  - Sickle cell trait (Adult & Pediatric) **D57.3**
- **Endocrine, Nutritional & Metabolic Disease (E00-E89)**
  - Type 1 diabetes mellitus **E10**
  - Type 1 diabetes mellitus without complications **E10.9**
  - Type 2 diabetes mellitus without complications **E11.9**
  - Protein-calorie malnutrition (Adult) **E44**
  - Protein-calorie malnutrition (Pediatric) **E46**
  - Morbid obesity due to excess calories **E66.01**
    **Use additional code to identify body mass index (BMI)*
  - Cystic fibrosis **E84**
  - Hyperkalemia/Potassium Overload **E87.5**
  - Hypokalemia/Potassium Deficiency **E87.6**

Add 4th – 7th digits 3 Digit Reportable

Other Conditions: Adult & Pediatric Codes (F–I)

Mental, Behavioral & Neurodevelopmental Disorders (F01-F79) **For MB&N, code first any associated physical and developmental disorders*	
Mild intellectual disabilities **F70**	
Moderate intellectual disabilities **F71**	
Severe intellectual disabilities **F72**	
Profound intellectual disabilities **F73**	
Autistic disorder, current or active state **F84.0**	
Asperger's syndrome/disorder **F84.5**	
Attention-deficit hyperactivity disorder, predominantly hyperactive type **F90.1**	Attention-deficit hyperactivity disorder, predominantly inattentive type **F90.0**
Attention-deficit hyperactivity disorder, combined type **F90.2**	

Disease of the Nervous System (G00-G99)
Parkinson's disease **G20**
Dementia **F01, F02, F03**
Dementia with Parkinson's **G20**, **F03.90**
Restless leg syndrome **G25.81**
Multiple sclerosis **G35**
Epilepsy/seizures **G40**
Cerebral Palsy **G80**
Paraplegia/ Quadriplegia **G82**

Disease of the Circulatory System (I00-I99)
Essential (primary) hypertension **I10**
Atherosclerotic heart disease without angina pectoris **I25.10**
Old myocardial infarction **I25.2**
Primary pulmonary hypertension **I27.0**
Cardiomyopathy **I42**
Chronic atrial fibrillation **I48.2**
Heart failure **I50**
Peripheral vascular disease **I73**

- **Use any additional codes if necessary**
- **Code dementia specificity based off the etiology and severity**

Add 4th – 7th digits 3 Digit Reportable

Other Conditions: Adult & Pediatric Codes (J–N)

- **Disease of the Respiratory System (J00-J99)**
  **Use additional code to identify exposure to tobacco smoke, dependence or use of tobacco*
  - Simple chronic bronchitis **J41.0**
  - Chronic bronchitis **J42**
  - Emphysema **J43**
  - Other chronic obstructive pulmonary disease **J44**
  - Asthma **J45**
- **Disease of the Digestive System (K00-K95)**
  - Esophageal Reflux (Pediatric) **K21.9**
  - Cirrhosis of liver **K74**
  - Celiac disease **K90.0**
- **Disease of the Skin & Subcutaneous Tissue (L00-L99)**
  - Lupus erythematosus **L93**
- **Disease of the Musculoskeletal System & Connective Tissue (M00-M99)**
  - Rheumatoid arthritis **M06**
  - Systemic Lupus **M32**
  - Degenerative disc disorders, thoracic, thoracolumbar, or lumbosacral **M51**
  - Scoliosis **M41**
  - Osteoporosis **M80-M81**
  - Degenerative disorders, cervical **M50**
  - Other specified disorders of bone **M85.8**
- **Disease of the Genitourinary System (N00-N99)**
  - Chronic kidney disease **N18**
  - Unspecified kidney failure **N19**
  - Nocturnal Enuresis (Pediatric) **N39.44**
  - Enlarged prostate **N40**

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- **Use Z13.828 for screening of rheumatoid arthritis or signs and symptoms until diagnosis confirmed by rheumatologist**

Other Conditions: Adult & Pediatric Codes (R–Z)

- **Symptoms, Signs & Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified (R00-R99)**
  - Unspecified urinary incontinence **R32**
  - Delayed Milestones (Pediatric) **R62**
  - Adult failure to thrive **R62.7**
- **Congenital Malformations, Deformations & Chromosomal Abnormalities (Q00-Q99)**
  - Spina Bifida **Q05**
- **Factors Influencing Health Status & Contact with Health Services (Z00-Z99)**
  - Asymptomatic HIV Infection **Z21**
  - Body mass index (BMI) 40 or Greater, adult **Z68**
  - Long term (current) use of insulin **Z79.4**
  - History (personal and family) codes **Z80-Z87**
  - Amputation **Z89**
  - Tracheostomy **Z93.0**
  - Ileostomy **Z93.2**
  - Gastrostomy **Z93.1**
  - Colostomy **Z93.3**
  - Transplant organ and tissue status **Z94**
  - Cardiac pacemaker **Z95.0**
  - Cardiac defibrillator **Z95.810**
  - Dependence on supplemental oxygen **Z99.81**
  - Dependence on renal dialysis **Z99.2**

**When coding for BMI, a 5th digit is needed for specificity of BMI percent*

Add 4th – 7th digits 3 Digit Reportable

Social Determinants of Health (For Medicaid and Medicare Memebrs)

- SDoH are the conditions in which people are born, grow, work, live and age.
- HPP recommends all patients be screened for social determinants of health at least once a year.
- Identified barriers should be revisited in subsequent visits and appropriate codes should continue to be submitted.
- Code and submit appropriate SDoH ICD-10 diagnoses codes that have been identified with HCPCS codes.

Codes below must be submitted via claims

- **HCPCS G9919**
  - SDoH assessment completed and positive (barriers identified)
  - Code with SDoH ICD-10 Dx code(s)
- **HCPCS G9920**
  - SDoH assessment completed and positive (barriers identified)

Description Categories of SDoH Diagnosis Codes

- Problems related to education and literacy (Z55)
- Problems related to employment and unemployment (Z56)
- Occupational exposure to risk factors (Z57)
- Problems related to housing and economic circumstances (Z59)
- Problems related to social environment (Z60)
- Problems related to upbringing (Z62)
- Other problems related to primary support group, including family circumstances (Z63)
- Problems related to certain psychosocial circumstances (Z64)
- Problems related to life management difficulty (Z73)
- Personal history of psychological trauma, not elsewhere classified (Z91.4)

Please ensure that you are using the specific, billable diagnosis code(s), not the non-billable header codes (e.g., Z55, Z56, Z56.8, etc.).

Please use these reference codes for claim billing purposes. Improper coding can reduce claim payment accuracy, causing unnecessary denials and further delay in claims reimbursements.

For more information, please call us at **1-888-991-9023**
or contact your Network Account Manager.

Medicare STARS: Screenings & Assessments

Measure: Breast Cancer Screening		
HEDIS: The percentage of MA female enrollees aged 50–74 who had a mammogram during the past 2 years		
Mammogram	CPT:	**77055-77057,77061-77067**
	HCPCS:	**G0328**

Access and Appointment Standards	
Criteria	**Standard**
Routine Office Visit	Within 10 days
Routine Physical	Within 3 weeks
Preventive Care	Within 3 weeks
Urgent Care	Within 24 hours

Measure: Colorectal Cancer Screening		
HEDIS: The percentage of MA enrollees aged 50–75 who had appropriate screening for colon cancer		
FOBT (measurement year)	CPT:	**82270, 82274**
	HCPCS:	**G0328**
Flexible Sigmoidoscopy (measurement year or 4 years prior)	CPT:	**45330-45335, 45337-45342, 45345-45347,45349-45350**
	ICD-10 Procedure:	**45.24**
	HCPCS:	**G0104**
Colonoscopy (measurement year or 9 years prior)	CPT:	**44388-44394, 44397, 44401-44408, 45355, 45378-45387, 45398**
	ICD-10 Procedure:	**45.22, 45.23, 45.25, 45.42, 45.43**
	HCPCS:	**G0105, G0121**
FIT-DNA (measurement year or 2 years prior)	CPT:	**81528**
	HCPCS:	**G0464**
CT Colonography (measurement year or 4 years prior)	CPT:	**74261-74263**

Medicare STARS: Care for the Adult & Osteoporosis Management

Measure: Care for Older Adult *HEDIS: The percentage of MA enrollees 66 years and older who had each of the following during the measurement year*	**Code Description**	**Codes**
Advanced Care Planning	CPT: CPT Category II: HCPCS:	**99483, 99497** **1123F, 1124F, 1157F, 1158F** **S0257**
Medication Review	CPT: CPT Category II:	**90863, 99483, 99605, 99606** **1160F**
Medication List	CPT Category II: HCPCS:	**1159F** **G8427**
Functional Status Assessment	CPT: CPT Category II: HCPCS:	**99483** **1170F** **G0438-G0439**
Pain Assessment	CPT Category II:	**1125F, 1126F**

Measure: Osteoporosis Management in Women who had a Fracture		
HEDIS: The percentage of female MA enrollees 67–85 and older who suffered a fracture during the measurement year, and who subsequently had either a bone mineral density test or were prescribed a drug to treat or prevent osteoporosis in the six months after the fracture		
Bone Mineral Density Test	CPT:	**76977, 77078, 77080, 77081, 77085, 77086**
	ICD-10 Procedure:	**BP48ZZ1, BP49ZZ1, BP4GZZ1, BP4HZZ1, BP4LZZ1, BP4MZZ1, BP4NZZ1, BP4PZZ1, BQ00ZZ1, BQ01ZZ1, BQ03ZZ1, BQ04ZZ1, BR00ZZ1, BR07ZZ1, BR09ZZ1, BR0GZZ1**
		G0130
Osteoporosis Medication Prescription	HCPCS:	**J0897, J1740, J3110, J3111, J3489**

Medicare STARS: Diabetes (Eye) & Diabetes (Kidney Disease Monitoring/Nephropathy)

Measure: Comprehensive Diabetes Care – Eye Exam		
HEDIS: The percentage of diabetic MA enrollees 18–75 with diabetes (type 1 and type 2) who had an eye exam (retinal) performed during the measurement year		
Retinal Ophthalmoscopic Exam	CPT:	**67028, 67030-67031, 67036, 67039-67043, 67101, 67105, 67107-67108, 67110, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220-67221, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92134, 92225-92228, 92230, 92235, 92240, 92250, 92260, 99203, 99204, 99205, 99213, 99214, 99215, 99242-99245**
	CPT Category II:	**2022F, 2024F, 2026F**
	HCPCS:	**S0620, S0621, S3000**

Measure: Comprehensive Diabetes Care – Kidney Disease Monitoring/Nephropathy		
HEDIS: The percentage of diabetic MA enrollees 18–75 with diabetes (type 1 & type 2) who had medical attention for nephropathy during the measurement year		
Nephropathy Screening	CPT:	**82042, 82043, 82044, 84156**
	CPT Category II:	**3060F, 3061F**
Macroalbuminura Test Positive	CPT:	**81000-81003, 81005**
	CPT Category II:	**3062F**
Nephropathy Attention	CPT:	**36147, 36800, 36810, 36815, 36818, 36819-36821, 36831-36833, 50300, 50320, 50340, 50360, 50365, 50370, 50380, 90935, 90937, 90940, 90945, 90947, 90957-90962, 90965, 90966, 90969, 90970, 90989, 90993, 90997, 90999, 99512**
	CPT Category II:	**3066F, 4010F**
	ICD-10 Procedure:	**E08.21, E08.22, E0829, E09.21, E09.22, E09.29, E11.21, E11.22, E11.29, E13.21, E13.22, E13.29, I 12.0, I 12.9, I 13.0, I 13.10, I 13.11, I 13.2, I 15.0, I 15.1, N00.0-N08, N14.0-N14.4, N17.0-N17.2, N17.8-N17.9, N18.1-N18.6, N18.9, N19, N25.1, N25.81, N25.89, N25.9, N26.1, N26.2, N26.9, Q60.0-Q60.6, Q61.00, Q61.01, Q61.02, Q61.11, Q61.19, Q61.2, Q61.3-Q61.9, R80.0-R80.3, R80.8, R80.9**

Medicare STARS: Diabetes (Blood Sugar Control), Controlling Blood Pressure & Additional Information

Measure: Comprehensive Diabetes Care – Blood Sugar Control		
HEDIS: The percentage of diabetic MA enrollees 18–75 whose most recent HbA1c level is lower than 9%, or who were not tested during the measurement year		
HbA1c Test	CPT:	**83036, 83037**
	CPT Category II:	**3075F – Testing Outcome: Syst BP <140 MM HG** **3077F – Testing Outcome: Syst BP > or equal to 140 MM HG** **3078F, 3079F – Testing Outcome: Diast BP <90 MM HG** **3080F – Testing Outcome: Diast BP > or equal to 90 MM HG**

High Risk Medications

CMS uses the Beers Drug List to identify certain drugs with a high risk of serious side effects in the elderly population when there may be safer drug choices. We encourage providers to conduct a medication review and educate members on the adverse effects of some of the drugs they may be taking and seek after alternatives.

Please use appropriate resources for determining your CPT code for services vendor.

- 2021 CPT Code Book
- CMS Resources
  - **www.CMS.gov**
- American Medical Association Resources
  - **www.ama-assn.org**

E/M Services and Guidelines Overview

- Review new 2021 CPT coding changes and guidelines to office visits.
- Update coding books, software and billing, etc.
- Train coding and billing staff on changes.
- The medical record documentation must support the level of service reported.
- You should not use the volume of documentation to determine which specific level of service to bill.
- Billing the appropriate level for the medical service you provided with supportive medical record documentation will maximize your clinical revenue as well as decrease the risk of a possible audit.
- History and physical exam should be performed but does not determine code selection.
- CPT code 99201 is deleted.
- CPT code 99211 the time element has been removed.
- No modifier changes.

Tips for E/M CPT Coding

- The complexity of the service needs to be documented and clear for someone else to see when reviewing the medical record.
- Do not document to a level; document on how sick the patient is and the quality of care you provided.
- Procedure codes and diagnosis codes should be supported in documentation.
- ICD-10 codes provide detail and support the quality of service.
- Include time in your documentation when considering using time as your decision on choosing a level.
- Do not use other billable services to include in your total time.
- The final diagnosis for a condition does not determine the complexity or risk.
- Clarify if you're ordering, reviewing or interpreting and from what specific with date.
- Be clear on who is managing the prescription.
- Document all treatment options and if there is refusal.
- Document plan for each diagnosis.
- Document if the SDoH is affecting the patient's condition(s); clarify if still present.
- + 99417 or G2212 (Prolonged Time Services) codes can only be used with 99205 or 99215.
- Align your assessment, treatments and plans together.
- Someone else must see the complexity in the record, not just you.

E/M Services and Guidelines Changes for 2021

The E/M level of service is now based on the following:

Level of medical decision making (MDM) as defined for each service

OR

Total time for E/M services performed on the date of encounter.

- Refer to the new level medical decision making table.
- Total time includes face-to-face and non-face-to-face time on the date of the encounter.
- CPT code 99211 the time element has been removed.
- No modifier changes.

Medical Decision Making Table

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making
		Number and Complexity of Problems Addressed
99211	**N/A**	N/A
99202 **99212**	**Straightforward**	**Minimal** • **1** self-limited or minor problem
99203 **99213**	**Low**	**Low** • **2** or more self-limited or minor problems; **or** • **1** stable chronic illness; **or** • **1** acute, uncomplicated illness or injury
99204 **99214**	**Moderate**	**Moderate** • **1** or more chronic illnesses with exacerbation, progression, or side effects of treatment; **or** • **2** or more stable chronic illnesses; **or** • **1** undiagnosed new problem with uncertain prognosis; **or** • **1** acute illness with systemic symptoms; **or** • **1** acute complicated injury
99205 **99215**	**High**	**High** • **1** or more chronic illnesses with severe exacerbation,progression, or side effects of treatment; **or** • **1** acute or chronic illness or injury that poses a threat to life or bodily function

Elements of Medical Decision Making	
Amount and/or Complexity of Data to be Reviewed and Analyzed **Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	**Risk of Complications and/or Morbidity or Mortality of Patient Management**
N/A	N/A
Minimal or none	**Minimal risk of morbidity from additional diagnostic testing or treatment**
Limited *(Must meet the requirements of at least 1 of the 2 categories)* **Category 1: Tests and documents** • **Any combination of 2 from the following:** • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test* **or** **Category 2: Assessment requiring an independent historian(s)** *(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)*	**Low risk of morbidity from additional diagnostic testing or treatment**
Moderate *(Must meet the requirements of at least 1 out of 3 categories)* **Category 1: Tests, documents, or independent historian(s)** • **Any combination of 3 from the following:** • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test*; • Assessment requiring an independent historian(s) **or** **Category 2: Independent interpretation of tests** • Independent interpretation of a test performed by another physician/other qualified health care professional *(not separately reported)*; **or** **Category 3: Discussion of management or test interpretation** • Discussion of management or test interpretation with external physician/other qualified health care professional\appropriate source *(not separately reported)*	**Moderate risk of morbidity from additional diagnostic testing or treatment** *Examples only:* • Prescription drug management • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social determinants of health
Extensive *(Must meet the requirements of at least 2 out of 3 categories)* **Category 1: Tests, documents, or independent historian(s)** • **Any combination of 3 from the following:** • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test*; • Assessment requiring an independent historian(s) **or** **Category 2: Independent interpretation of tests** • Independent interpretation of a test performed by another physician/other qualified health care professional *(not separately reported);* **or** **Category 3: Discussion of management or test interpretation** • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source *(not separately reported)*	**High risk of morbidity from additional diagnostic testing or treatment** *Examples only:* • Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization • Decision not to resuscitate or to de-escalate care because of poor prognosis

Time Code Range

New Code	Time Range
99202	15-29 minutes
99203	30-44 minutes
99204	45-59 minutes
99205	60-75 minutes

Established Code	Time Range
99212	10-19 minutes
99213	20-29 minutes
99214	30-39 minutes
99215	40-54 minutes

Special Investigations Unit (SIU)

Accurate billing of claims will help avoid unnecessary denials, overpayment requests and/or referrals to law enforcement.