The
ENCOUNTER CLASSIFICATION HANDBOOK
for
MILITARY OCCUPATIONAL AND ENVIRONMENTAL MEDICINE

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This 4th Edition of the Encounter Classification Handbook (formerly titled The Coding Manual and known as the "Orange Book") is the result of the collaborative efforts and work by Diana Stuart, CPC, CPC-H, CPMA, CEMC, CCS-P, CRS, Lisa Rosenthal, CCS-P, LCDR Anne R. McDonough, MC, CAPT Alan Philippi, MC, Loraine O'Berry, COHN-S, Adriene Simmons, COHN-S, and John Muller, MD, MPH. A minor update (March 4, 2014) corrected typographical errors. A second minor update (March 28, 2014) corrected the B-12 code to 96372, and clarified the use of V25.09. A third minor update (July 11, 2014) included minor typographical changes to increase format consistency.

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1. Introduction

This manual introduces the unique aspects of encounter classification, generally referred to as "coding," for Military Occupational and Environmental Medicine (OEM). It is important to assign diagnosis, Evaluation and Management, and CPT procedure codes accurately for biostatical data, resource allocations, third party billing collection, and ultimately the continuity of quality patient care. This manual is designed as a help to OEM providers and staff. It is not to be used by coders, as it is not an authorized coding manual.

Note: While abbreviations have been used in some tables to enhance readability, DoD policy is not to use abbreviations, and readers are cautioned against using abbreviations when ordering or documenting patient care.

1.1. Coding and Documentation Tips for Occupational Environmental Medicine

1.1.a.1. Clearly state why the patient is presenting (i.e., well visit, medical certificate, or condition for problem oriented visit). See paragraph 3.1.

1.1.a.2. A new patient is one who is new to the practice and has not been seen within the last three years. See paragraph 4.2.

1.1.a.3. Non-privileged providers are limited to using codes:

1.1.a.3.a. 99211 (Nurse/Tech) Evaluation and Management (E&M) level. See paragraph 5.1.a.

1.1.a.3.b. Procedure(s) and/or service(s) performed

1.1.a.3.b.1. Use CPT code for procedure and/or service and 99499 when the patient presents for the procedure only.

1.1.a.3.b.2. Document all details regarding the service(s) provided. See paragraph 5.1.g.

1.1.a.4. Patient check-in and check-out encounters with non-privileged providers are coded as an administrative visit with CPT code 99499. See paragraph 5.1.

1.1.a.5. When a privileged provider spends greater than 50% of the E&M visit counseling and/or coordinating patient care for a problem oriented E&M, time is selected in the AHLTA disposition screen. Non-privileged providers may not use this option. See paragraph 4.2.

1.1.a.6. Use an external cause code (E-code) only when a patient presents for initial injury care to the military treatment facility (MTF). Document how, when and where the injury occurred. E-codes are not used on subsequent visits for the injury or when referred for follow up care in Occupational Health. See paragraph 0.

1.1.a.7. Use an ICD-9-CM code for the condition that prompted the workers' visit. See paragraph 3.1.a.

1.1.a.8. Use an ICD-9-CM injury code in lieu of an ICD-9-CM symptom code when applicable. See paragraph 3.1.

1.1.a.9. Include details for any test(s) and/or procedures performed during the encounter. See paragraph See Section 5.1.d.

1.1.a.10. Tests performed prior to the physician's appointment (usually during part I of the physical examination) should be appended to the provider's AHLTA encounter for the part II portion of the service. See paragraph 5.1.d.

1.1.a.11. Exposure visits should be coded as problem focused visits (usually 99213 with supporting documentation). See paragraph 4.2.

1.1.a.12. Preventive Medicine codes (99381-99397) represent well visits and should only be coded once for the physical examination regardless of the number of return visits for the same physical examination. These services are performed in the absence of complaints or symptoms. See paragraph 4.3.

1.1.a.13. Problem oriented visits (99201 – 99215) are coded when the patient presents for an injury, illness, or follow-up visit. They can also be coded with a Preventive Medicine code when documentation supports an additional problem-focused service is performed. See paragraph 4.3.b .

1.1.a.14. A Preventive Medicine CPT code (99381-99397) and a problem-oriented E&M CPT code (99201-99215) may both be coded for the same patient on the same date of service if the E&M service represents a significant, separately identifiable service. Append modifier 25 the second E&M service. See paragraph 4.3.c.

1.1.a.15. Preventive Medicine services include counseling. When counseling is provided with a Preventive Medicine code (99381-99397) on the same date of service, only the Preventive Medicine service is coded. This includes smoking cessation counseling. See paragraph 4.3.a.

1.1.a.16. The comprehensive nature of a Preventive Medicine code (99381-99397) reflects an age and gender appropriate examination. When a screening service is provided with a Preventive Medicine service on the same date of service by the same specialty provider, only the Preventive Medicine service is coded. See paragraph 4.3.

1.1.a.17. Prolonged service codes (99354 and 99358) should not be coded with Preventive Medicine E&M Services. According to CPT, the use of the time based add-on codes require that the primary evaluation and management service have a typical or specified time published in the CPT codebook. Preventive Medicine Services do not have typical or specified time. See paragraph 4.6.

1.1.a.18. Smoking counseling (99406-99407) provided during a problem oriented E&M can be coded separately when supported. Use diagnosis code 305.1 (tobacco abuse) and V65.42 (counseling). See paragraph 4.3.b.

1.1.a.19. EKGs performed during part I of the physical examination should be documented by the performing support staff (i.e., nurse or tech) in the privileged provider's note and coded by the privileged provider during part II of the service. See paragraph 4.8.b.

1.1.a.20. An initial visit to the clinic with a nurse or tech should be coded as 99499. A patient is not established in the clinic until seen by a privileged provider. See paragraph 5.1.a.

1.1.a.21. Use code V68.09 when issuing a medical certificate. See paragraph 3.3.c.2.

1.1.a.22. Use code V22.2 (incidental pregnancy) as a secondary code when applicable. The date of conception and estimated delivery date must be documented in the note. See Table 3.7.

1.2. Health Examination Coding Guidance Tables

Table 1.1 Evaluation & Management Health Examination Coding Guidance

ENCOUNTER TYPE	E&M
Encounter for well exam, <1 years, new patient	99381
Encounter for well exam, <1 years, established	99391
Encounter for well exam, 1-4 years, new patient	99382
Encounter for well exam, 1-4 years, established patient	99392
Encounter for well exam, 5-11 years, new patient	99383
Encounter for well exam, 5-11 years, established patient	99393
Encounter for well exam, 12-17 years, new patient	99384
Encounter for well exam, 12-17 years, established patient	99394
Encounter for well exam, 18-39 years, new patient	99385
Encounter for well exam, 18-39 years, established patient	99395
Encounter for well exam, 40-64 years, new patient	99386
Encounter for well exam, 40-64 years, established patient	99396
Encounter for well exam, 65 years or older, new patient	99387
Encounter for well exam, 65 years or older, established patient	99397
Encounter no exam, counseling provided to an individual, 15 minutes (with provider)	99401
Encounter no exam, counseling provided to an individual, 30 minutes (with provider)	99402
Encounter no exam, counseling provided to a group, 30 minutes (with provider)	99411
Encounter no exam**,** counseling provided to a group, 60 minutes (with provider)	99412
Encounter record review only (face to face), no exam, no counseling, reviewed by provider (physicians, NPs, PAs or IDCs)	99420
Encounter record review, no exam, no counseling, reviewed by provider (physicians, NPs, PAs or IDCs)	Do Not Code *
Encounter for illness, injury, follow-up, etc.	99201-99215
Encounter Nurse/Tech Visit, face to face, no privileged provider contact, established patient	99211
Encounter Nurse/Tech Visit, face to face, no privileged provider contact, new patient	99499

Table 1.2 DoD Extender for Health Examination Code V70.5

Extender	Purpose	Description
V70.5_0	Armed Forces Medical Exam	Pre-enlistment General Exam
V70.5_1	Aviation Exam	Initial qualifying and any recurring aviation exam
V70.5_2	Periodic Health Assessments	Includes PHA (DD2766)
V70.5_3	**Occupational Exam**	**Includes initial certifying and recurring exams**
V70.5_4	Pre-Deployment Related Encounter	Related to a projected deployment. Not pre-deployment assessment
V70.5_5	Intra-Deployment Related Encounter	Includes family members experiencing deployment related condition
V70.5_6	Post-Deployment Related Encounter	Includes family members experiencing deployment related condition
V70.5_7	**Duty Status Determination/Suitability Exam**	**Includes return to work and disability evaluation**
V70.5_8	Special Program Accession Encounter	Prior service entry to officer programs
V70.5_9	Separation/Retirement Exam	
V70.5_A	Health Exam of Defined Subpopulations	School Physicals, etc.
V70.5_B	Abbreviated Sep/Retirement Exam	Partial exam updating complete exam within a defined period
V70.5_C	PRT Screening	Identified conditions are secondary codes
V70.5_D	Pre-Deployment Assessment	Identified conditions are secondary codes
V70.5_E	Initial Post-Deployment Assessment	Identified conditions are secondary codes
V70.5_F	Post-Deployment Health	Identified conditions are secondary codes
V68.09	Issuance of Medial Certificate	Use only as primary code, do not use in conjunction with V70.X

2. Coding Concepts

2.1. Capturing Patient Services

2.1.a. In the past, workload measured by number of patient visits was the basis for reimbursement of MTFs. Reimbursement now depends on identifying the types of patient services provided rather than a simple count of visits.

2.1.b. The military adopted civilian sector coding systems. Policy requires that military clinics use these codes in the same manner as their civilian counterparts. The Military Health System Coding Guidance at www.Tricare.mil/ocfo/bea/ubu/coding_guidelines.cfm supplements the coding systems with military-specific direction and takes precedence in the event of conflicting guidance. Inaccurate coding in both military and civilian clinics can lead to criminal and/or monetary penalties. "Overcoding" for services beyond those provided and documented constitutes fraud. "Undercoding" results in a lower workload accountability and insufficient reimbursement to support the services provided. Documentation in the patient record must support medical necessity and substantiate the codes selected. The provider is ultimately responsible for the coding.

2.2. Coding Systems

2.2.a. The International Classification of Disease, 9th Revision - Clinical Modification (ICD-9-CM) is the DIAGNOSIS coding system describing why the practice provided services to the patient, thereby establishing the medical necessity of the care provided. The ICD-9-CM manual is updated annually on October 1st. A three-digit code represents the general diagnosis, with up to two additional digits after the decimal adding additional detail. The first step in identifying the services provided is establishing the medical necessity of the patient visit through ICD-9-CM diagnostic coding.

2.2.b. The Healthcare Common Procedure Coding System (HCPCS) Level I, commonly known as Current Procedural Terminology (CPT), is the coding system describing the type of PROCEDURES and SERVICES that were provided to the patient. Updates to CPT occur annually on January 1st. CPT codes are five digits and can further describe or explain services rendered. CPT modifiers consists of two digits and provide the means to report a procedure or service that has been performed yet altered by some specific circumstance without changing the code's definition. After ICD-9-CM diagnostic codes establish the medical necessity of the visit, CPT codes determine the amount of reimbursement for services. A subset of CPT codes, Evaluation and Management (E&M) codes, describe COMPLEXITY of care provided, PLACE of service, and TYPE of service. Higher intensity of care results in higher reimbursement.

2.2.c. HCPCS Level II is a "catch-all" for reporting SUPPLIES and services for which no CPT codes exist. It often identifies durable medical equipment and supplies. Ensuring that applicable HCPCS Level II codes are used is the final step to coding a visit. Proper coding of HCPCS Level II codes captures all practice expense so that the clinic can be budgeted adequately each year to meet their patient demands.

2.2.d. On October 1, 2014,the current DoD ICD-9-CM coding system (with 13,600 codes) will be replaced with ICD-10-CM (with more than 69,000 diagnosis codes). ICD-10 uses seven alphanumeric characters that comprise an entirely new system (i.e., no diagnosis code is the same in both ICD-9 and ICD-10).

2.3. Reimbursement and Workload Credit

2.3.a. Relative Value Units (RVUs) assigned to most CPT codes determine the workload credit for the patient encounter. Higher complexity services receive higher RVUs. Under the prospective payment system, an average RVU is worth about $74 reimbursement to the MTF, depending on the specialty.

2.3.b. The mechanism by which a military clinic submits its "claim" for reimbursement for outpatient services is provider entry of ICD-9-CM, CPT, and HCPCS Level II codes describing the patient encounter in the Armed Forces Health Longitudinal Technology Application (AHLTA). The billing system (TPOCS) then

transfers this information from AHLTA onto a CMS-1500 Medical Claim Form for payment by the appropriate insurance company.

2.3.c. Coding is important to collect reimbursement from individuals who have other health insurance, to receive MFT funding and workload credit (used in performance evaluations, e.g., FITREPs), and for prevention and epidemiologic analysis.

2.3.d. The provider is ultimately responsible for coding and documentation. For questions on coding issues, please contact the Service Representative, as follows:

Army http://www.pasba.amedd.army.mil

Air Force https://phsohelpdesk.brooks.af.mil or 1-800-298-0230

Navy Coding Hotline Share Point

https://es.med.navy.mil/bumed/m3/m35/M35HO/m3/HO/ICD10/CodingCommunity/default.aspx

3. ICD-9-CM Diagnostic Coding

3.1. Injury and Illness Coding

3.1.a. ICD-9-CM coding for evaluation and treatment of acute injuries and illnesses in the occupational health clinic is essentially the same as in an emergency department or primary care clinic. The worker's symptom, sign, or diagnosis translates into an ICD-9-CM code, which establishes the medical necessity of the visit. Table 3.1 lists some ICD-9-CM codes commonly used in Occupational Environmental Medicine (OEM) clinics.

3.1.b. Use only the ICD-9-CM code for the condition that prompted the worker's visit, regardless of other chronic conditions that may be present, unless those conditions directly influenced the care of the patient. For example, an employee under treatment for hypertension who sustains a foot laceration will be coded only as 892.0 (under category Open Wound) followed by an external cause code in AHLTA. The laceration, not essential hypertension, resulted in provision of services to this employee. However, if a diabetic patient with a peripheral circulatory disorder presents with a laceration of the foot, more aggressive care may be necessary. In that case, the code for diabetes with a peripheral circulatory disorder (250.7x) and the manifestation, such as peripheral angiopathy (443.81) are coded in addition to the foot laceration (892.0) and E code of the first presentation to the MTF. A fifth digit is required for all category 250 codes to identify the type of diabetes mellitus (type I or II) and whether the diabetes is controlled or uncontrolled. Note: Medical information not pertinent to the occupational injury, certification, or surveillance exam should generally be avoided. The non-occupational medical record should not be read, and historical information not related to occupation should not be added to the occupational medical record. Specifically, to avoid violating the Genetic Information Nondiscrimination Act of 2008 (GINA), Family History is not to be reviewed during medical surveillance and certification examinations.

3.1.c. Care for an illness or injury may arise during the course of a preventive visit such as a medical surveillance exam. In this instance, expanded documentation should include the complete record of the injury or illness as well as all elements of the preventive visit. The injury or illness receives an ICD-9-CM diagnostic code to describe the medical necessity of the problem oriented service. The CPT coding chapter provides more detail on coding these types of visits.

3.1.d. Although AHLTA provides a rudimentary look-up of ICD-9-CM codes, it does not include all of the coding rules and information contained in the ICD-9-CM manual. AHLTA should not be relied on for coding.

3.1.e. Use of the coding manual is counterintuitive, as one usually starts with Volume 2 (the alphabetic index) using the diagnostic term for the injury or illness. Associated with this term will be a three-digit number or number range. Enter the tabular index (Volume 1) using this number. Select the highest order number, up to five digits, that matches the employee's specific injury or illness. Do not select the code given from the alphabetic index without checking the tabular index for more specific diagnosis codes numbered beyond the decimal place of the three-digit code and any pertinent coding guidelines (i.e., multiple coding required, etc.). Do not use a symptom code when a definitive diagnosis is established.

3.1.f. If an employee has signs and symptoms but no diagnosis yet, refer to Section 16 of the ICD-9CM book titled, "Signs, Symptoms, and Ill-Defined Conditions." The use of these codes is acceptable as specific diagnosis codes from the billing perspective since the important issue is why the employee sought care in the OEM clinic, not the diagnostic acumen of the provider.

3.1 ICD-9-CM Codes Commonly Used

Illnesses, Signs & Symptoms

789.00 Abdominal Pain
781.2 Abnormal Gait
477.9 Allergic Rhinitis
786.2 Cough
780.6 Fever
784.0 Headache
724.2 Low Back Pain
782.0 Numbness
278.00 Obesity, Unspecified
305.1 Tobacco Use Disorder
V15.82 Tobacco User History
465.9 Acute URI NOS
305.01 Alcohol Abuse, Cont.Use
780.97 Altered Mental Status
285.9 Anemia, Unspecified
719.47 Ankle (Foot Joint) Pain
300.00 Anxiety State, Unspecified
401.1 Benign Hypertension
786.50 Chest Pain, Unspecified
276.51 Dehydration
V58.67 Diabetes – Long Term Insulin
250.01 Diabetes Type I, Controlled
250.00 Diabetes Type II, Controlled
780.4 Dizziness/Vertigo NOS
715.09 DJD – Multiple Sites
305.91 Drug Abuse, Cont, Unsp
787.91 Diarrhea NOS
787.2 Dysphagia
782.3 Edema
719.42 Elbow (Upper Arm Joint) Pain
796.2 Elevated BP w/o Dx HTN
492.8 Emphysema NOS
719.44 Finger (hand Joint) Pain
780.96 Generalized Pain
530.81 GERD
346.90 Headache, Migraine, Unspec
307.81 Headache, Tension
719.45 Hip (Pelvic Region Joint) Pain
V65.43 Injury Prevention Counseling
719.49 Joint Pain (Multiple Sites)
719.46 Knee (Lower Leg Joint) Pain
780.79 Malaise/Fatigue/Weakness
401.0 Malignant Hypertension
787.02 Nausea Alone
V65.3 Nutritional Counseling
786.02 Orthopnea
715.90 Osteoarthrosis, Unspecified
729.5 Pain in Limb
300.01 Panic Disorder
462 Pharyngitis, Acute
486 Pneumonia
518.89 Pulmonary Nodule NEC Lung Dz
780.39 Seizure Disorder NOS
786.05 Shortness of Breath
719.41 Shoulder Joint Pain
729.81 Swelling in Limbs
780.02 Transient Alteration of Awareness
401.9 Hypertension, Unspec
599.0 Urinary Tract Infection, Unspec
787.01 Vomiting w/ Nausea
719.43 Wrist (Forearm Joint) pain

Injuries & Accidents

915.0 Abrasion/Friction Burn, Finger
924.21 Ankle, Contusion
871.3 Avulsion of Eye
924.20 Black Heel
923.20 Black Palm
921.0 Black eye NOS
930.0 Corneal Foreign Body
931 Ear Foreign Body
923.11 Elbow Contusion
959.3 Elbow/Forearm/Wrist Injury
921.9 Eye Contusion/Injury, Unspec
959.09 Face/Neck Injury Unspec
920 Face/Scalp (except eyes) Contusion
923.3 Finger Contusion
923.10 Forearm Contusion
873.42 Forehead/Eyebrow Laceration
959.01 Head Injury Unspec
924.01 Hip Contusion
924.11 Knee Contusion
959.7 Knee/Leg/Ankle/Foot Injury
924.10 Lower Leg Contusion
932 Foreign Body in Nose
873.1 Scalp Laceration Complicated
873.0 Scalp Laceration Uncomplicated
884.0 Arm Laceration (Wound)
882.0 Hand Laceration
883.0 Finger Laceration
891.0 Leg Laceration
892.0 Foot Laceration
923.00 Shoulder Contusion
959.2 Shoulder/Upper Arm Injury
733.94 Stress Fracture Metatarsals
733.95 Stress Fracture Other Bone
733.93 Stress Fracture Tibia/Fibula
924.00 Thigh Contusion
924.3 Toe Contusion (Talon Noir)
983.1 Toxic Effects of Acid
985.1 Toxic Effects of Arsenic
986 Toxic Effects of Carbon Monoxide
983.0 Toxic Effects of Corrosive Aromatics
984.0 Toxic Effects of Inorganic Lead
985.0 Toxic Effects of Mercury
984.1 Toxic Effect of Organic Lead
984.8 Toxic Effects of Other Lead
985.8 Toxic Effects of Thallium
983.9 Toxic Effects of Unspecified Caustic
984.9 Toxic Effects of Unspecified Lead
985.9 Toxic Effects of Unspecified Metals
989.5 Toxic Effects of Venom

Spine & Back

739.9 Abdominal & Other Sites Somatic Dys
739.1 Cervical Somatic Dysfunction
724.6 Disorder of the Sacrum
739.0 Head Somatic Dysfunction
739.6 Lower Ext Somatic Dysfunction
739.3 Lumbar Somatic Dysfunction
733.90 Osteopenia
733.00 Osteoporosis, unspec
739.5 Pelvic Somatic Dysfunction
739.8 Rib Cage Somatic Dysfunction
739.4 Sacral Somatic Dysfunction
724.3 Sciatica
737.30 Scoliosis, Idiopathic
724.8 Symptoms of the Back
724.1 Thoracic Pain
739.2 Thoracic Somatic Dysfunction
724.4 Thoracic/Lumbosacral Radiculitis, Unspec
724.9 Back Disorder, Unspec
724.5 Back Pain, Unspec
739.7 Upper Ext Somatic Dysfunction

Sprains & Strains

845.00 Ankle, Unspec
847.9 Back, Unspec
845.01 Deltoid Ligament, Ankle
841.8 Elbow/Forearm, Specified
841.9 Elbow/Forearm, Unspec
845.10 Foot, Unspec
842.10 Hand, Unspec
843.9 Hip/Thigh, Unspec
844.2 Knee, Cruciate Ligament
844.8 Metatarsophalangeal (Joint)
844.9 Knee/Leg, Unspec
844.0 Lateral Collateral Knee Ligament
847.2 Lumbar Spine
844.1 Medical Collateral Knee Ligament
845.12 Metatarsophalangeal (joint)
847.0 Neck (Whiplash Injury)
846.9 Sacroiliac Region, Unspec
847.3 Sacrum (Sacrococcygeal Ligament)
840.9 Shoulder/Upper Arm, unspec
848.1 Temporomandibular (Joint/Ligament)
847.1 Thoracic Spine
842.00 Wrist, Unspec

3.2. External Cause Codes (E-codes)

3.2.a. For external causes of injury, poisoning and adverse reactions, the ICD-9-CM classification contain E-codes which provide additional information about where, why, and how an injury occurred. This information is helpful in epidemiologic analysis and population-level prevention efforts. E-codes may never serve as primary diagnosis codes; they merely supplement the information provided by the primary diagnosis code. For example, the coded diagnoses 883.0, E920.5, E849.7 means a puncture wound to the finger (883.0), due to a hypodermic needle (E920.5), occurring at the hospital (E849.7).

3.2.b. Use E-codes only during the first patient visit to the MTF for the injury. E-codes are not used on follow-up visits UNLESS the injury is war-related. For war-related injuries, the E-code is used at all follow-up visits.

3.2.c. AHLTA requires entry of E-codes for ICD-9-CM codes recognized as injury diagnoses. Chapter 5 contains more information on entry of E-codes in AHLTA. Documentation should include the date and circumstances surrounding the injury.

3.2.d. E-codes are located at the end of the alphabetic index in the ICD-9-CM book in Volume 2. Like the numeric codes, E-codes have a hierarchical organization. Table 3.2 contains frequently used E-codes in OEM.

3.2.e. Initial encounters for hearing loss acquired from performance of duties, but not associated with physical trauma to the head, should be identified with the appropriate E code as a secondary diagnosis.

Table 3.2 External Cause Codes Used Frequently in OEM

External Cause	E Code	External Cause	E Code
Accident by Caustic/Corrosive substance	E924.1	Fall from chair	E884.2
Accident by Hot Liquid/Vapors or Steam	E924.0	Fall into hole other opening	E883.9
Accident by Hot Substance/Object	E924.8	Fall-slipping, tripping & stumbling	E885.9
Accident Poisoning by Arsenic	E866.3	Foreign body in eye & adnexa	E914
Accident Poisoning by Lead	E866.0	Hornet, wasp & bee stings	E905.3
Accident Poisoning by Mercury	E866.1	Human Bite	E928.3
Accident Poisoning by Metals	E866.4	Hypodermic needle stick accident	E920.5
Cause-Electric Current	E925.1	Lifting machine and appliance	E919.2
Cause-Other Hand Tools/Implement	E920.4	Metal working machine	E919.3
Cause-Other Powered Hand Tools	E920.1	Woodworking & forming machine	E919.4
Conflagration, burning bldg/structure	E891.3	Motor vehicle collision NOS	E812.0
Conflagration, explosion bldg/structure	E891.0	Other spec air transport accidents	E844.0
Conflagration, fumes P\(PVC) bldg/structure	E891.1	Other specified machinery	E919.8
Conflagration, other accident bldg/structure	E891.8	Overexert/strenuous movement from pull, lift & pushing	E927
Conflagration, smoke and fumes bldg/structure	E891.2	Poisoning by corrosives & caustics	E864.0
Excessive heat-weather/man-made	E900.1	Poisoning by motor exhaust	E868.2
Explosion/Fire/Burning Watercraft (un-powered)	E837.0	Struck accidently by falling object	E916
Exposure to noise pollution	E928.1	Vibration	E928.2
Accident occurring at place of work	E849.3	Accident occurring in parking lot	E849.8

Table 3.3 War Related External Cause Codes

Injury due to war operations from rubber bullet (rifle)	E991.0	Injury due to war ops from pellet (rifle)	E991.1
Injury due to war ops from bullet	E991.2	Injury due to war ops from anti-personal bomb	E991.3
Injury due to war ops from bullet and pellet fragments from roadside IED	E991.7	Injury due to war ops from unspecified source	E990.9
Injury due to war ops by explosion of marine torpedo	E992.0	Injury due to war ops by aerial bomb explosion	E993.0
Injury due to war ops by explosion of marine depth charge	E992.1	Injury due to war ops by guided missile explosion	E993.1
Injury due to war ops by explosion of marine mines	E992.2	Injury due to war ops by mortar	E993.2
Injury due to direct or indirect pressure or air blast from a person-borne improvised explosive device (IED)	E993.3	Injury due to direct or indirect pressure or air blast from a vehicle-borne improvised explosive device (IED)	E993.4
Injury due to war ops by destruction of aircraft due to enemy fire or explosives	E994.0	Injury due to war ops struck by blunt object	E995.1
Injury due to war ops by direct blast effect of nuclear weapons	E996.0	Injury due to war ops but occurring after cessation of hostilities by explosion of mines	E998.0
Injury due to war ops from gasoline bomb	E990.9	Injury due to war ops by laser	E997.0
Injury due to war ops by biological warfare	E997.1	Injury due to war ops by gas/fumes/chemical	E997.2
Injury due to specified form of unconventional warfare	E997.8	Injury due to unspecified form of unconventional warfare	E997.9

3.3. V-codes

3.3.a. OEM services frequently provide care to workers without specific symptoms or diagnoses, such as medical surveillance or job certification exams. The V-code classification is provided to deal with occasions when other than an injury or disease is the reason for the encounter. Illness and injury codes, as discussed in the previous chapter, cannot describe medical necessity for these visits of apparently healthy workers. Instead, a subset of ICD-9-CM codes, called V-codes, describes the medical necessity of preventive and administrative care.

3.3.b. V-codes are a separate section of the tabular index of the ICD-9-CM Manual, Volume 1. Like the injury and illness codes, additional digits add specificity to the code.

3.3.c. Two V-codes commonly describe medical necessity for preventive exams by OEM physicians. Use these codes only as the primary (i.e., first-listed) code for the visit.

3.3.c.1. V70.5 codes for health exams of a defined population such as groups of workers in medical surveillance programs. This code has special Department of Defense extenders that add more detail, for instance to code for an occupational health assessment, use V70.5_3. See Table 1.2.

3.3.c.2. V68.09 encounters are for administrative purposes such as the issuance of a medical certificate, rating, or statement. Medical certificates are most often part of an examination or physical and do not receive a separate code. However, when no medical indication for the encounter exists; the patient's reason for the encounter was solely to obtain a medical certificate, no other code more appropriately reflects the primary reason for the encounter, and the provider does not evaluate or treat any symptoms, conditions, or diseases, use V68.09 and the appropriate E&M office level.

Table 3.4 V-Codes For Occupational Examinations

Type of Service	V-Code	E&M Code	CPT Code
Occupational exam, initial and recurring, no symptoms	V70.5_3	993xx Age appropriate preventive exam	99172/3 Visual acuity 93000 EKG, interpretation & report* 93005 EKG, tracing only 93010 EKG, interpretation only 92551/2/3 Audiometry tests
Occupational exam for duty status/ suitability determination (re-enlistment, change in status of temporary and permanent duty retirement list, medical evaluation board and return to duty following pregnancy or surgery and treatment	V70.5_7	993xx Age appropriate preventive exam	99172/3 Visual acuity 93000 EKG, interpretation & report* 93005 EKG, tracing only 93010 EKG, interpretation only 92551/2/3 Audiometry tests
Occupational exam with symptoms, disease, or acute exacerbation of chronic illness	V70.5_7 Exam xxx.xx Symptom or disease	993xx Age appropriate preventive exam and 992xx Problem oriented E&M service appended with modifier -25.	List any procedures performed
Occupational exam with chronic illness (not active)	V70.5_7 Exam xxx.xx Symptom or disease	993xx Age appropriate preventive exam	List any procedures performed
Occupational exam, injury or illness influencing work status	xxx.xx Symptom or disease	992xx Problem oriented E&M service	List any procedures performed
Return-to-Work after injury or illness, with no symptoms	V68.09	992xx Problem oriented E&M service**	List any procedures performed

*The global EKG code 93000 is used by the privileged provider on the physical examination encounter when both components of the service are performed in the same clinic, regardless if on different dates of service.
**When documentation supports the use of 99211, it is appropriate for providers to use the 99211 code.

3.3.d. Visits including preventive counseling and education, such as a reproductive hazard evaluation, require V-codes to describe medical necessity of the education or counseling provided. These codes are secondary codes to the appropriate primary diagnostic or other V-codes. Table 3.5 provides some helpful secondary V-codes for describing these visits. (Note: V25.09 is under contraceptive management and should not be used for "counseling" unless done as part of family planning.)

Table 3.5 Secondary V-codes for OEM Education and Counseling

V-code	Education Topic
V65.49_6	Occupational Exposure Education
V65.49_5	Travel Medicine Education
V62.1_0	Occupational Stress Education
V62.2	Dissatisfaction W/Employment
V15.84	Exposure to Asbestos
V15.85	Exposure to Hazardous Body Fluid
V15.3	Exposure to Irradiation
V15.86	Exposure to Lead
V72.0	Eye & Vision (SCP)
V65.43	Injury Prevention
V65.3	Nutritional Counseling
V22.2	Pregnancy Incidental
V26.49	Reproductive Concerns/Hazard
V82.89	Submarine Pressure Screening

3.3.e. Table 3.6 summarizes diagnostic coding of hearing tests performed in conjunction with the Hearing Conservation Program. Civilian ICD-9-CM coding guidelines limit both V70 and V72 codes to

first-listed status and use of code V70.5 therefore typically should exclude V72.xx. However, the Department of Defense wishes to identify the specific type of hearing conservation program exam performed and has issued superseding guidance to report both codes for hearing conservation program exams.

Table 3.6 V-codes for Hearing Conservation Program Exams

Encounter Type	ICD-9-CM
Military Accession Exam – No Abnormalities	V70.5_8 and V72.1*
Military Accession Exam – Abnormalities	V70.5_8 and V72.1* plus 794.15**
Baseline Exam – No Abnormalities	V70.5_3 and V72.1*
Baseline Exam – Abnormalities	V70.5_3 and V72.1* plus 794.15**
Annual Exam – No Identified STS	V70.5_3 and V72.1*
Annual Exam – Initial STS	V70.5_3 and V72.1* plus 794.15**
Annual Exam – Previously Confirmed PTS	V70.5_3 AND 388.1X* or 389.XX
Follow-up 1 or 2 For STS	794.15**
Termination Exam	V70.5_9 and V72.1*

* 4th and 5th digits and applicable DoD extender code required to indicate a specific condition or encounter.

**For non-professionals (e.g., technicians or nurses). Physicians or audiologists may diagnose noise-induced hearing loss.

3.3.f. For individuals receiving occupational audiology evaluation after an abnormal screening evaluation, V-code extenders in Table 2-4 apply.

Table 3.7 Code Extenders for Occupational Audiology Evaluations

Encounter Type	ICD-9-CM Code
Examination of Ears and Hearing	V72.1
Hearing Examination Following Failed Hearing Screening	V72.11_0
Hearing Examination Following Failed Hearing Screening, Otoscopic Exam Done	V72.11_1
Hearing Examination Following Failed Hearing Screening, Otoscopic Exam Not Done	V72.11_2
Other Examination of Ears and Hearing	V72.19_0
Other Examination of Ears and Hearing, Otoscopic Exam Done	V72.19_1
Other Examination of Ears and Hearing, Otoscopic Exam Not Done	V72.19_2

3.3.g. For individuals receiving immunizations as required by medical surveillance, the V and E-codes in Table 3.8 through Table 3.12 apply.

Table 3.8 V-codes for Immunizations

Immunizations *Vaccines or Medication Name*	ICD-9-CM V-code	Administration CPT Code	CPT/HCPCS Code
Anthrax	V03.89	90471/90472 each add vaccine	90581
B-12	266.2 or per MD order	96372	J3420
Chicken Pox (Varivax) Varicella	V05.4	90471/90472	90716
Depo Provera 1 mg	V25.49	96372	J1050
DTaP < 7 yrs	V06.5	90471/90472	90700
DT, Pediatric, <7 yrs.	V04.81	90471/90472	90702
Flu Shot, split virus 6-35 mos.	V04.81	90471/90472	90657
Flu Shot, split virus >3 yrs.	V04.81	90471/90472	90658
Flu Mist (intranasal)	V05.3	90471/90472	90660
Hep A, 1-18 years, 2 Dose Schedule	V05.3	90471/90472	90633
Hep A, Adult	V05.3	90471/90472	90632
Hep B, 0-19 years, 3 Dose Schedule	V05.3	90471/90472	90744
Hep B, Adult, 20+	V05.3	90471/90472	90746
HPV – Gardasil V04.89	V05.8	90471/90472	90649
Twinrix, Hep A & Hep B, Adult	V05.8	90471/90472	90636
HIB (3 dose vaccine) PRP – OMP	V03.81	90471/90472	90647
IPV (Polio) IM or SUBQ	V04.0	90471/90472	90713

Immunizations *Vaccines or Medication Name*	ICD-9-CM V-code	Administration CPT Code	CPT/HCPCS Code
JEV (Japanese Encephalitis Virus)	V05.0	90471/90472	90735
Meningococcal (2-10 yrs. old) **Menemune**	V03.89	90471/90472	90733
Meningococcal (10 yrs. or older) **Menactra con**	V03.89	90471/90472	90734
MMR	V06.4	90471/90472	90707
MMRV (ProQuad)	V06.8	90471/90472	90710
Pediarix (DTaP, IPV, Hep B)	V06.8	90471/90472	90723
Pneumococcal, conj. <5 yrs.	V03.82	90471/90472	90669
Pneumovax, Adult or immunosuppressed patient	V03.82	90471/90472	90732
PPD Placement (TB test)	V74.1	[redacted]	86580
PPD – Read NEGATIVE	V74.1	[redacted]	[redacted]
PPD – Read POSITIVE	795.5	[redacted]	[redacted]
Rabies IM	V04.5	90471/90472	90675
Rotavirus 3 Dose Sched, Live, for Oral use	V04.89	90473	90680
Synagist (Per 100mg vial)	V04.82	90771	90378
Td, Adult >7	V06.5	90471/90472	90718
Tdap IM >7 yrs and older V06.1	V06.8	90471/90472	90715
Tetanus toxoid	V03.7	90471/90472	90703
Typhoid IM (ViCPs)	V03.1	90471/90472	90691
Typhoid Oral	V03.1	90473	90690
Yellow Fever	V04.4	90471/90472	90717
Zoster (Shingles) SUBQ	V05.8	90471/90472	90736
PERSERVATIVE FREE (PF)			
Flu Shot, split virus 6-35 mos., PF	V04.81	90471/90472	90655
Flu Shot, split virus >3, PF	V04.81	90471/90472	90656
Tetanus and Diphtheria toxoids (Td) age >7, PF	V06.5	90471/90472	90714
Administration Codes If injected and oral/nasal given concurrently, always list the injection first. If you administer more than one, each additional injectable would be coded as a 9047 **Use 90473 if you administer orally or by nasal with no other vaccine. If you administer more than one vaccine orally or by nasal then add 90474**			

Table 3.9 V-codes for Immune Globulins

Immune Globulin	ICD-9-CM V-code	Administration CPT Code	CPT/HCPCS Code
Immune Globulins (Ig) IM	V04.89	96372	90281
Respiratory syncytial virus immune globulin (RSV-IgIM) PER UNIT 50 mg	V04.82	96372	90378
Tetanus Immune Globulin (TIg) IM 01 PFS	V03.89	96372	90389
Rabies Immune Globulin (Rig-HT), HT 10 1vi	V04.5	96372	90376
SHOT TRANSCRIPTION ON TO SPECIAL FORM – such asPH731/State SchPE Form etc.			
Special Reports/Forms	V68.09		99080

Table 3.10 V-codes for Smallpox Vaccine

Smallpox Vaccine	ICD-9-CM V-code	Administration CPT Code	CPT/HCPCS Code
Smallpox ($202 vial)	V04.1		90471/90472
Provider supervised Group Education Service (DoD required briefing)	V65.49 with extender code		99411 approx. 30 mins 99412 approx. 60 mins

Smallpox Vaccine	ICD-9-CM V-code	Administration CPT Code	CPT/HCPCS Code
Provider supervised Provision Educational Supplies (Mandatory Tri-fold)			99071
Provider service: smallpox review/reporting of status (screen form clearance w/ reporting)			99071
Counseling class provided by Nurses/Corpsmen	V65.49 with extender code		S9445 individual S9446 group
Special Foam Dressing, wound cover, 16 sq. inch or less, adhesions (per unit – usually 6 given -)			A6212
Purell			99070
Other Therapies; Non-MD Patient Education and Counseling Non-MD Instruction for Patients			S9445

Table 3.11 E Codes for Vaccine Adverse Events

ICD-9-CM Code	ADVERSE EFFECTS – Nurses use if initiating VAERS (Vaccine Adverse Event Reporting System)	CPT/HCPCS Code
E948.5	Diphtheria	99080
E948.9	Mix (combination)	99080
E948.6	Pertussin	99080
E948.4	Tetanus	99080
E949.4	Measles	99080
E948.8	Lyme's Vic	99080
E949.6	Mumps	99080
E949.5	Polio	99080
E949.1	Rabies	99080
E948.1	Typhoid	99080
E949.3	Yellow Fever	99080
E949.0	Smallpox	99080
E948.8	Bacterial, other and unspecified	99080
E949.9	Other-unspecified vaccines and biological substances	99080

Table 3.12 V-codes for Vaccine Non-completion

ICD-9-CM Code	Vaccination Non-Completion Event	CPT/HCPCS Code
V64.00	Vaccination not carried out, unspecified reason	99080
V64.01	Vaccination not carried out because of acute illness	99080
V64.02	Vaccination not carried out because of chronic illness or condition	99080
V64.03	Vaccination not carried out because of immune comprised state	99080
V64.04	Vaccination not carried out because allergy to vaccine or component	99080
V64.05	Vaccination not carried out because of caregiver refusal	99080
V64.06	Vaccination not carried out because of patient refusal	99080
V64.07	Vaccination not carried out for religious reasons	99080
V64.08	Vaccination not carried out because patient had disease being vaccinated against	99080
V64.09	Vaccination not carried out for other reason	99080

4. Coding For Privileged Provider Services

4.1. Evaluation and Management Categories in OEM

4.1.a. Evaluation and management (E&M) codes are the subset of CPT codes that quantify the work done by the privileged provider or other qualified health care professional (i.e., PA, NP, etc.) during (or associated with) a patient encounter. E&M codes, CPT procedure codes, and HCPCS Level II codes together determine the reimbursement for the patient visit. For specialties such as OEM, E&M codes are the largest contributor to reimbursement.

4.1.b. Different categories of E&M codes apply to different types of visits. Table 4.1 outlines the E&M categories pertinent to OEM clinics.

Table 4.1 E&M Categories Used in OEM

Category Subcategory	Codes
Problem-Oriented Services	
New Patient	99201 – 99205
Established Patient	99211 - 99215
Preventive Medicine Services	
New Patient	99381 – 99387
Established Patient	99391 – 99397
Preventive Medicine Counseling Services	
Individual Counseling	99401 – 99404
Group Counseling	99411 – 99412
Smoking cessation counseling	
3 – 10 minutes	99406*
10+ minutes	99407*
Physician Educational Services (Patients w/ established diagnosis)	
Group Education	99078
Individual Education	Use E&M level
Case Management Services	
Case Management, each 15 minutes	T1016
Team Conferences	99366 – 99368
Telephone Calls (Privileged Providers only)	99441 – 99443
On-Line Medical Evaluation	99444
Prolonged Services	
Direct Patient Contact	99354 – 99355*
Without Direct Patient Contact	99358 – 99359*
Special Services	
Work-Related or Medical Disability Evaluation	99455 – 99456**

* Cannot be used with Preventive Medicine Services codes 99381-99397

**Precludes use of 99080 CPT procedure Code

4.2. Problem-Oriented Evaluation and Management Services

4.2.a. OEM practices that provide acute care use the same E&M codes (99201 – 99215) as primary care clinics. This code range represents non-procedural services and is distinguished by either a new or established patient. A new patient is one who has not received any professional services from the physician/qualified health care professional or another physician/qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years. An established patient is one who has received services within the past three years. A new patient visit receives a higher reimbursement than an established patient visit for the same level of complexity. The five levels of service are minimal, problem focused, expanded problem focused, detailed, and comprehensive. Privileged providers typically do not use E&M 99211 unless their documentation is deficient. The provider, not AHLTA, selects the appropriate E&M code level for the patient visit. A privileged provider is an independent practitioner who is granted permission to provide medical, dental,

and other patient care in the granting facility, within defined limits, based on the individual's education, licensure, experience, competence, ability, health, and judgment. Resident physicians are not independent practitioners but are included as privileged providers for coding purposes. Chapter 4 addresses use of the minimal level of service code by support staff.

4.2.b. Three key components, history, exam, and medical decision making determine the appropriate E&M level for a problem-oriented visit. Only documented services contribute to the level of complexity. DoD requires the utilization of medical decision making as a mandatory component of an established patient E&M assignment. The provider may choose between the history and physical exam for the second component to determine E&M code assignment for the encounter.

4.2.c. Four contributory factors can increase the E&M level of an encounter in certain circumstances: nature of presenting illness, coordination of care, counseling, and time. If more than 50% of the visit is spent counseling or coordinating care, these factors become a key component of the E&M level. If time is a key component for the encounter, document the counseling topics or coordination of care that occurred and include the total face-to-face time plus the counseling / coordinating time. This time does not include procedures and other services and resident or support staff time with the patient. Prolonged E&M services are used for direct patient contact or before or after patient care (see section 4.6). Reporting any code that is measured by time only must be supported within the providers' documentation. The DoD coding rule states when a provider selects greater than 50% of time spent "counseling and/or coordination of care" and also selects the appropriate amount of face-to-face time, excluding time spent for procedure(s) or other services, then the time in and time out requirement has been met in AHLTA. Detailed documentation must indicate specifics on the counseling or coordination of care, discussion of why the additional time was necessary, what occurred during the additional time, and how much time was spent. **Note:** The statement "Discussed: Diagnosis, Medication(s)/Treatment(s), Potential Side Effects with Patient who indicated understanding" is not acceptable documentation in and of itself.

4.2.d. Content of documentation, not volume, determines the E&M code. The component with the lowest level of documentation determines the E&M level. By knowing the elements required to code each component to a higher level of service, you can ensure that your documentation accurately reflects your workload. Templates, in particular, can ensure that you do not lose an E&M level by failing to document services that you performed.

4.2.e. Each of the three key components depends on specific elements to determine its level of complexity. Documentation of the history of present illness; review of systems; and past medical, family, and social history determines the level of complexity for the history component. Occupational history is part of social history for coding purposes. The physical exam component depends on the number of elements evaluated in organ systems and body areas. Medical decision-making complexity is based on the presenting problems, diagnostic procedures or management options selected on the Table of Risk (See section 10). Section 9 provides expanded information on the history exam and medical decision making components.

4.2.f. After determining the level of complexity for each of the three key components, find the final E&M level for the visit in Section 10. Again, remember that the lowest complexity component drives the level of service for a new patient. If three components are completed for an established patient, medical decision making is always one of two key components used to determine the E&M level.

4.3. Preventive Medicine Services

4.3.a. Preventive Medicine Services include a comprehensive history and physical examination, anticipatory guidance, risk factor reduction interventions and counseling, the ordering of appropriate immunizations or laboratory/diagnostic procedures, and the management of insignificant problems.

4.3.b. The E&M codes for Preventive Medicine Services describe routine examinations performed in the **absence** of patient complaints or symptoms. These services include medical surveillance exams, disability evaluations, and fitness for duty determinations. Age, rather than documented complexity of care, determines the E&M level for preventive medicine services. Like E&M codes for problem-oriented visits, preventive medicine codes also distinguish between new and established patients. These services include counseling/anticipatory guidance/risk factor reduction interventions which are provided at the time of the initial or periodic comprehensive preventive medicine examination. Time is not a factor in the selection of this code; therefore prolonged E&M services cannot be used in addition to these codes.

4.3.c. Note that if an employee raises a specific complaint during a medical surveillance exam, the visit may constitute both a problem-oriented and preventive services visit if the complaint requires significant time and resources for its evaluation and management. In this case, document the problem-oriented visit separately from the preventive visit with a second SOAP (Subjective, Objective, Assessment, and Plan) note and code to reflect both services provided. Use a preventive services E&M code linked to the appropriate ICD-9-CM V-code. Then, use a problem- oriented service E&M with modifier -25 linked to the injury and illness ICD-9-CM code describing the symptom, sign, or diagnosis. Table 4.2 provides guidance in differentiating problem-oriented, preventive medicine, and combined visits.

Table 4.2 Differentiating Preventive Medicine Visits from Problem-Oriented Visits

	Preventive Medicine Visit	Problem-Oriented Visit	Preventive Visit with Problem
Chief Complaint	Health Patient No Complaints Insignificant/ Trivial Problem	Chief Complaint	Healthy patient with significant complaint
History of Present Illness	Not Problem Oriented No Present Illness Described Pertinent Risk Factors Assessed	Limited to presenting problem	Includes history related to age/gender and present illness
System Review, Past, Family, Social History (PHSHx)	Comprehensive System review Comprehensive PFSH (PSHx)	Pertinent to presenting problem	Comprehensive system review/PFSH + evaluation of presenting problem
Examination	Based on age, risk factors	Appropriate to presenting problem	Age and risk factor based on exam + evaluation of presenting problem
Assessment and Plan	Screening for Ancillary Services Plan typically counseling, anticipatory guidance, risk factor reduction	Medical decision-making reflected in assessment, ancillary service(s) ordered for specific medical problem	Screening + medical decision making

4.3.d. Code diagnoses, symptoms, or signs discovered during a preventive services visit but do not require significant time and resources to support a problem focused E&M as secondary ICD-9-CM codes.

4.4. Preventive Medicine Counseling Services

4.4.a. A frequent service of OEM clinics is counseling individuals and groups of patients. As an example of this service, consider an industrial operation that potentially exposes an individual employee or group of employees or non-employees to overexposure of toxins, fumes, or physical hazards. An employee may be educated about the signs and symptoms that he or she might experience in the event of an overexposure. This service is preventive counseling.

4.4.b. A common coding error is using a preventive medicine, individual, or group counseling code rather than an education code when a condition, symptom, or disease exists. Using the previous example, if the OEM staff educates employees following an overexposure, this is a problem-oriented visit rather than preventive counseling.

4.4.c. Levels for these E&M codes depend on the amount of time that the provider spends with the individual or group. See Table 4.1.

4.4.d. ICD-9-CM codes for these encounters are V-codes described in Section 3.

4.5. Case Management Services

4.5.a. Case management codes report coordination of care with other providers or employers without a patient encounter on that day. A medical team conference by the provider with an interdisciplinary team of health professionals, face-to-face with the patient and/or family, 30 minutes or more is coded with a 99366 E&M code. A team conference of less than 30 minutes is not reported separately. If the medical team conference is conducted with the patient and/or family not present for 30 minutes or more, the provider must be responsible for direct care of the patient and for supervising health care services needed by the patient. Therefore, these codes do not apply to conferences involving an employee who has not been under the provider's care (e.g., team review of worker's compensation claim).

4.5.b. Medical team conferences include face-to-face participation by a minimum of three qualified health care professionals (e.g. MD, DO, NP, PA, Therapists (excludes nurses, corpsmen, clergy)) from different specialties with or without the presence of the patient, family member(s), community agencies, surrogate decision maker(s) (e.g., legal guardian), and/or caregiver(s). The participants must be actively involved in the development, revision, coordination, and implementation of health care services needed by the patient. Reporting participants shall have performed face-to-face evaluations of treatments of the patient, independently of any team conference, within the previous 60 days, in any setting.

4.5.c. Do not code site visits that are not associated with care of an individual patient. However, if a work site evaluation occurs in conjunction with individual patient care (e.g., to clarify reasonable accommodations in a fitness for duty evaluation) or as part of an interdisciplinary team, case management E&M codes apply.

4.5.d. The team conference starts at the beginning of the team's review of an individual patient and ends at the conclusion of the team's review.

4.5.e. Time related to record keeping and report generating is not used for determining the time reported.

4.5.f. Medical Team Conference codes:

- 99366 – Medical team conference with interdisciplinary team of health care professionals, face-to-face with patient and/or family, 30 minutes or more, participation by non-physician qualified healthcare professional. Use E&M code (99201-99215) when service is provided by the physician with the patient and/or family present.
- 99367 - Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; PARTICIPATION BY PHYSICIAN.
- 99368 - Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; PARTICIPATION BY NON-PHYSICIAN QUALIFIED HEALTH CARE PROFESSIONAL.

4.6. Prolonged Services

4.6.a. Prolonged provider services are reported in addition to E&M codes when the length of time a provider spends with the patient goes at least 30 minutes beyond what is typical for that service. Use these secondary E&M codes only in conjunction with a problem-oriented, or special service E&M codes.

An example of a prolonged office visit would be the care of an acute asthmatic patient who warrants prolonged face-to-face provider care. Time does not have to be continuous however must be documented to support the additional time. Prolonged services can occur either with direct, face-to-face patient contact or without. Episodes of prolonged service without direct patient contact must occur either before or after direct patient care (within one week). A frequent use of prolonged services codes in OEM is the description of time required for record review before or after a disability evaluation or reproductive hazard evaluation. Time must be documented to support this series of codes.

4.6.b. Code prolonged services with direct patient contact as 99354 for 30 to 60 minutes and 99355 for each additional 30 minutes. Code prolonged services without direct patient contact as 99358 for 30 to 60 minutes and add 99359 for each additional 30 minutes.

4.7. Special Services

4.7.a. Work-related disability examinations fall under special E&M services. These exams include a history and physical examination appropriate to the employee's condition; formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment; development of a treatment plan; and completion of documentation including reports and certificates.

4.7.b. If the provider is treating the employee, code 99455 applies. E&M code 99456 applies if the provider is not treating the employee.

4.7.c. Do not use CPT procedure code 99080 (Special paperwork) in conjunction with these special service E&M codes since completion of certificates and reports is integral to the special services E&M code.

4.8. CPT Procedure Codes

4.8.a. Specific procedures performed during a problem-oriented or preventive services visit receive a CPT procedure code(s) and therefore additional workload credit in addition to the primary service. Frequent omission of these procedure codes leads to lost workload credit. Only code those procedures actually performed in (not ordered by) the occupational health clinic.

4.8.b. All procedures and services inclusive to the physical examination should be documented in the privileged provider's AHLTA note.

Table 4.3 outlines some of the more common procedural codes used in conjunction with OEM problem-oriented and preventive visits.

Table 4.3 Common CPT Procedural Codes for OEM

Procedure During Problem-Oriented Visit	Code
Problem-Oriented Visits	
Application of modality, hot or cold packs	97010
Educational materials given to the patient	99071
IV Infusion, first hour	96365
IV Infusion, each additional hour	96366
IV Push, Initial	96374
IV push, sequential	96375
Injection, subcutaneous or intramuscular (Medication)	96372
Orthotic management and training; each 15 minutes	97760
Tetanus toxoid absorbed (IM)	90703 (Vaccine) and 90471 (Administration >18 yrs. old) – one vaccine, 90472 – each additional vaccine. (Note: For <18 yrs. old, use 90460 for first vaccine and 90461 for each additional one).
Tetanus and diphtheria toxoids (Td) absorbed, preservative free, when administered to individuals 7 yo and older (IM)	90714 (Vaccine) and 90471 (administration same as above)
Diphtheria, tetanus toxoids, and whole cell pertussis vaccine and Hemophilus influenza B vaccine (DTP-Hib) (IM)	90720 (Vaccine) and 90471 (administration same as above
Venipuncture	36415
Laceration repair scalp/neck/trunk/ext; 2.5 cm or less	12001
Laceration repair scalp/neck/trunk/ext; 2.6 cm to 7.5 cm	12002
Laceration Repair face/ear/nose/lip/eyelid; 2.5 cm or less	12011
Laceration Repair face/ear/nose/lip/eyelid; 2.6 cm to 5.0 cm	12013
Preventive Visits	
Venipuncture	36415
Spirometry	94010
Tympanometry	92567
Visual Acuity	99172/3
Color Vision	92283
Vision Field Exam	92081-92083 (limited, intermediate, extended)
EKG	93000 – Global 93005 (tracing only) 93010 (interpretation and report only)
PPD Placement	86580
Guaiac Test	82270
Urine Dip stick	81002
Audiometry	Screening, pure tone, air only, 92551 Pure tone (threshold), air only, 92552 Testing of groups, 92559

4.8.c. Immunizations given at point of service (i.e., in the clinic performing the physical) are coded on the same encounter as the physical.

4.8.d. Electrocardiograms have a global code (93000) used when the tracing, interpretation, and report are completed in the SAME CLINIC. In this case, the technician performing the test should be included as an additional provider on the privileged provider's encounter. If the tracing and interpretation/report are performed in SEPARATE CLINICS, the clinic performing the tracing codes 93005 for the tracing only. The provider privileged to interpret and report the ECG/EKG then uses 93010 upon completing the EKG report to code the professional component. Interpretation without a written report does not receive a separate CPT procedure code, but is part of the medical decision-making complexity in determining the E&M code for the visit. For example, an EKG (93000) performed during the first part of the exam, even if on a different date of service in the same clinic, is documented in the future AHLTA note and coded by the privileged provider with 93000. This service cannot be broken down into two components when both services are performed in the same clinic.

4.8.e. Table 4.4 provides CPT codes describing special services that may apply to OEM providers. As CPT codes, they confer additional workload credit if coded when applicable.

Table 4.4 Special Procedure Codes for OEM

Special Services	CPT Code
Services provided in office at times other than regularly scheduled office hours*	99050
Services provided on emergency basis in office which disrupts other scheduled services*	99058
Medical testimony	99075
Special reports such as insurance forms	99080

*Use in addition to basic service

4.9. Other Services

4.9.a. A telephone call initiated by an established patient to a privileged provider, to include IDC's and residents beyond post-graduate year one (PGY1), constitutes an episode of care per military coding guidance. Privileged providers may choose from the three E&M codes for telephone calls (99441, 99442, and 99443). Non-privileged providers may choose from the three CPT codes for telephone calls (98966, 98967, and 98968). Classification of a call is based on its duration. Documentation of the call must contain evidence of medical decision making by a privileged provider directly responsible for the management of the patient's care. Do not code telephone calls for provider–provider coordination, leaving messages on answering machines, or speaking with a Commander about an active duty member. This military-specific guidance on telephone calls differs from civilian CPT guidance.

4.9.b. A privileged provider online (email) evaluation and management to an established patient, guardian, or health care provider using the internet or similar electronic communications network is coded with the E&M code 99444. Do not use 99444 if originated from a related assessment and management service provided within the previous seven days. Under the same circumstances, a non-privileged provider would use 98969.

4.9.c. CPT code 99499 is used for provider initiated telephone calls, new patient interaction, providing test results without and medical decision making, provider-to-provider interaction, etc.

4.9.d. Routine audiograms for the hearing conservation program may occur in conjunction with a medical surveillance exam. In this case, the preventive services E&M for the surveillance exam includes the professional service (i.e., interpretation of the audiogram) and the additional CPT procedure code for the audiogram should be included with this visit. If a technician performs an audiogram without an associated preventive services visit, use 99499 in the E&M field as a placeholder and code the CPT procedure. If an audiologist evaluates a patient without t performing a procedure, use problem-oriented E&M codes based on the history, exam, and medical decision- making documented in the medical record. See Section 9.

5. Coding For Support Staff Services and Supplies

5.1. Occupational Health Nurses and Technicians

5.1.a. Support staff are normally restricted to using E&M code 99211 to document face-to-face encounters in which no procedure is performed (e.g., counseling or education) or code 99499 when a procedure is performed (e.g., audiogram, EKG). Code 99499 can also report other unique military data collection (e.g., technician review of a DD 2795). A patient must be established to the clinic before a non-privileged provider can use code 99211. Code 99499 is reported by the support staff for new patients that have not been established by the privileged provider.

5.1.b. Nurse telephone triage is assessment of a caller's medical condition using a protocol approved by the medical staff to provide non-privileged provider healthcare advice. Military coding guidance considers this service administrative overhead and assigns no RVUs for this function. Although collection of nurse telephone triage data is not required and not recommended, E&M code 99499 and the appropriate ICD-9-CM diagnostic code facilitates AHLTA documentation of the encounter.

5.1.c. Telephone calls solely for reporting test results are a continuation of the visit at which the provider ordered the test. Append documentation to the AHLTA record of that visit. Do not document telephone calls for administrative issues, such as reminding patients of appointments.

5.1.d. Occupational Medicine physical examinations conducted in two parts on different dates of service should be documented in the same encounter. Part I is provided by the support staff for necessary testing prior to the provider's part II physical examination. All services should be documented in the provider's AHLTA note. The support staff should open the future AHLTA appointment and add any test and services performed and add their name as the secondary provider.

5.1.e. Add occupational health nurses and technicians involved in a patient visit as secondary providers for the encounter. This documentation supports the necessity of staff in operation of the clinic.

5.1.f. Do not code the following clinic services:

- TB test reading
- Patient who presents for an order for pregnancy test only
- Blood pressure checks per patient request
- Patient who presents to pick up a prescription refill.

5.1.g. CPT procedure codes for support staff include those in Table 5.1. Use these codes whenever applicable. Either support staff or providers can enter these codes. Each clinic should develop a consistent procedure to ensure that coding for these services occurs. If the procedure does not occur in conjunction with a privileged provider visit, support staff uses the 99499 E&M placeholder in AHLTA. The health and behavior assessment, for instance, is applicable to an occupational health nurse's encounter with a patient with a needle-stick injury.

Table 5.1 CPT Codes for Support Staff

Description of Code	CPT Code
Education for patient self-management by credentialed nurse	
• Individual	98960
• 2-4 Patients	98961
• 5-8 Patients	98962
Health and Behavior assessment (i.e. needle sticks)	
• Initial assessment	96150
• Reassessment	96151
Educational material given to the patient (by provider or support staff)	99071
Counseling (V25.09)	

• Individual session • Group Session	S9445 S9446
Case Management Services • Telephone calls (non-privileged provider only) • Online assessment and management (non-privileged provider only)	 98966 – 98968 98969

5.2. Durable Medical Equipment and Supplies

5.2.a. HCPCS Level II contains the codes for most durable medical equipment and supplies. Do not code for equipment issued with the expectation that the patient will return it. Table 5.2 lists some commonly used equipment and supplies. Again, develop consistent procedures to ensure maximal coding of services provided.

Table 5.2 HCPCS Level II Supply Codes Commonly Used in OEM

Supply	Code	Supply	Code
Albuterol, inhalation solution, 1 mg	J7611	Ice Pack (not cap or collar)	A9999
Ice Cap or Collar	E0230	Kenalog, per 10 mg	J3301
Finger splint, static	Q4049	Generic Splint Supply	A4570
Benadryl, up to 50 mg	J1200	Suture removal Kit*	S0630
Cane, all materials, fixed or adjustable	E0100	Leg; Walking Boot (pneumatic)	L4360
Ceftriaxone Sodium, per 250 mg (Rocephin)	J0696	Lidocaine & Marcaine injection	Do not code bundled in proc)
Phenergan (up to 50 mg)	J2550	Light compression bandage, elastic, width <3 in. per yard. **	A6448
Crutches, underarm, pair (not wood)	E0114	Nitroglycerin, each	J3490
Gauze (non-adhesive) 16 sq. inch or less, each	A6216	Ringer's Lactate (up to 1 Liter)	J7120
Normal Saline Solution (up to 1 Liter)	J7030	Toradol, per 15 mg	J1885

*Only if sutures done elsewhere

**A6449Light compression greater than or equal to 3 in. and less than than or equal to 5 in. per yard and A6450 Light compression greater than 5 in. per yard

5.2.b. HCPCS Level II also encompasses some privileged provider services not included in the CPT procedure codes. Table 5.3 provides some common examples.

Table 5.3 HCPCS Level II Service Codes Commonly Used in OEM

Service	HCPCS Code
Digital Rectal Exam for Prostate Cancer Screening	G0102
Pap Smear Collection	Q0091

6. AHLTA and Coding

6.1. AHLTA Coding Features

6.1.a. Although AHLTA boasts automated coding features, correct output requires correct input. Understanding how these features work is one element necessary to ensure accurate coding. Coupled with development of consistent clinic-based procedures to coordinate the coding efforts of providers and support staff, this knowledge can lead to coding success. AHLTA has two specific coding features: a look-up for ICD-9-CM, CPT, and HCPCS Level II codes and an E&M code calculator. In addition to the specific coding features, customized templates and clinic lists can assist you in maximizing your coding accuracy and efficiency. AHLTA look-up features use keywords to offer codes that are potentially applicable to the patient visit. They do not contain the full information that is available in the coding manuals. In addition, the look-up functions are separate for each coding system (ICD-9-CM, CPT, and HCPCS), requiring you to know what type code you need. An alternative to using the look-up feature is to develop clinic lists of commonly used codes. This document contains most commonly used codes for OEM practice. Entry of these codes into lists of clinic favorites allows rapid retrieval of codes without using the look-up feature. For best coding accuracy, refer to a coding manual rather than the look-up if the code is not available here.

6.1.b. The E&M code calculator uses information from the AHLTA note to generate a suggested E&M level code. The default E&M category is “outpatient services” (i.e., problem-oriented). Since age alone determines E&M levels for preventive services, simply changing to the correct category usually leads to a correct code suggestion (unless the patient’s birth date is incorrect in DEERS).

6.1.c. The E&M code calculation for problem-oriented visits is more complicated. The calculator uses information entered using the MEDCIN tree (i.e., check boxes on AHLTA) to determine which elements of history and exam were completed, and uses the ICD-9-CM, CPT, and HCPCS codes to rate the medical decision making complexity. If you document elements of the history and exam using free text, the E&M code calculator does not recognize that you documented them and will under-code the visit. Therefore, if you choose to use free text for documentation in AHLTA, you should override the E&M code calculator on every visit.

6.1.d. Support staff can document subjective and objective information for the provider in AHLTA. The history of present illness (HPI), documented by the support staff, may only be counted towards E&M leveling if the provider’s documentation demonstrates he reviewed and expanded on the staff documentation. This could be accomplished in the electronic medical record by having the provider “edit” the nurse’s S/O section and add additional information in the HPI. Only those parts of the examination, and assessment/plan that are actually documented by the privileged provider may be used in calculating the level of the encounter. Any documentation, from provider, staff member, medical students or patient, may be used to calculate the level of the encounter for the ROS and PFSH.

6.1.e. When the provider takes ownership of documentation entered by support staff, these elements become part of the provider’s documentation and taking ownership indicates agreement with the information contained. These elements are recognized by the E&M code calculator.

7. Coding Scenarios

7.1. Example Coding Scenarios Described and Explained

7.1.a. **Scenario #1:** A 40-year-old explosives handler returns to the clinic for a biennial surveillance exam.

The clinic staff draws blood and takes the specimen to the lab. They also perform an EKG, which the provider interprets and documents the results in the visit note, an audiogram, and a visual acuity screening. No additional problems arise during the visit.

Coding:

ICD-9-CM:	Occupational Exam	**V70.5_3**
E&M:	Preventive Services, 40-64, Established Patient	**99396-25**
CPT:	EKG tracing and report	**93000**
	Venipuncture	**36415**
	Pure tone audiogram	**92552**
	Visual acuity	**99172**

7.1.b. **Scenario #2:** A 25-year-old worker not previously known to the clinic presents with a laceration on his right hand while using a non-powered hand tool. The location, mechanism of the injury, and the time at which it occurred is documented. He has no known drug allergies and had his last tetanus shot more than five years ago. Clinic staff has recorded his blood pressure, pulse, respirations, and temperature. The details of the 3 cm laceration repair are documented separately within the AHLTA note. The patient receives a tetanus immunization in the occupational health clinic. He also receives educational materials about signs and symptoms of infection.

Coding:

ICD-9-CM:	Open wound of hand, w/o complication	**882.0**
	Cause – Other hand tool/implement	**E920.4**
	Accident occurring in industrial workplace	**E849.3**
E&M:	Problem-Oriented Visit, New Patient	**99201-25***
CPT:	Laceration repair, 2.6-5 cm	**12002**
	Td Vaccine	**90718**
	Td Admin	**90471**
	Educational Materials	**99071**

*Documented History – Expanded Problem Focused (EPF), Exam - Problem Focused (PF), Medical Decision Making - Low, supporting 99201.

7.1.c. **Scenario #3:** A 60-year-old laboratory technician, who is a military beneficiary known to the clinic, presents for an annual surveillance for animal-associated diseases. The physical is performed and documented. He has diabetes, hyperlipidemia and smokes. Although he denies any symptoms associated with the rodents that he works with, he does note that he has had waxing and waning dull substernal chest pain since eating a large sausage dinner last night. He has no pain currently. Clinic staff placed a tuberculin skin test two days prior to the visit. An EKG is performed in the clinic, which is normal and a thorough cardiovascular and respiratory exam is performed. The PPD is negative. While

the clinic staff draws blood to check troponin levels, the provider contacts the patient's primary care physician to discuss further evaluation and care. 45 minutes is spent coordinating care without direct patient contact.

Coding:

ICD-9-CM:	Occupational exam	**V70.5_3**
	Pericardial pain	**786.51**
E&M:	Preventive services, 40-64 yo, Established Patient	**99396**
	Problem-oriented	**99214-25***
	Prolonged services	**99358**
CPT:	EKG	**93000**

*A documented History: Detailed, Exam: Detailed and Medical Decision Making: Moderate

7.1.d. **Scenario #4:** A 32-year-old Family Practice nurse who is a government service employee presents with an accidental needle stick during a routine blood draw in her clinic. The Occupational Health nurse (OHN) performs a problem oriented assessment of the wound and no physician intervention is needed for closure, etc. OHN proceeds to document a brief clinical history on the patient as well as known risk factors of the "needle" that punctured her finger. OHN reviews all risks with the patient as well as signs and symptoms to look for to show infection and/or possible adverse effect. OHN spends 30 minutes counseling the patient on health and behavior risk factors involved in a needle stick injury and answers all questions/concerns of the patient.

Coding:

ICD-9-CM:	Open Wound Finger, Uncomplicated	**883.0**
	Accidents by needle stick	**E920.5**
	Accident occurring in workplace	E849.3
E&M:	Unlisted E&M Service	**99499**
CPT:	Needle stick HRA Counseling	**96150 x 2***

*Note 96150 is a time based code, use units of service for every 15 minute interval.

7.1.e. **Scenario #5:** A 22 year old service member presents to the clinic for Part I of her pre-employment assessment. The tech reviews the medical record, performs the visual acuity test and documents what the patient needs to complete Part 2 of the PHA (i.e., immunizations, labs, etc.). No counseling is provided.

Coding:

ICD-9-CM:	Other Specified Administrative service	**V68.89**
E&M:	Unlisted E&M Service	**99499**
CPT:	Screening test of visual acuity	**99172/3**

7.1.f. **Scenario #6:** A 24 year old service member presents to the clinic for risk factor reduction counseling by a non-privileged provider (i.e., RNs, HMs, HNs). Documentation includes the details of counseling.

Coding:		
ICD-9-CM:	Counseling For Injury Prevention	**V65.43**
E&M:	Support Staff E&M	**99211**
CPT:	N/A	

7.1.g. **Scenario #7:** A patient presents to the clinic for part II of the PHA. The provider counsels the patient for 35 minutes on lifestyle modifications for risky behavior, preventive counseling based on family history and occupational exposure.

Coding:		
ICD-9-CM:	PHA	**V70.5_2**
	Inappropriate diet and eating habits	**V69.1**
E&M:	Preventive Medicine Counseling	**99402**
CPT:	N/A	

7.1.h. **Scenario #8:** A Flyer returning to active duty status presents for an evaluation of his/her condition.

Coding:		
ICD-9-CM:	Medical Certificate	**V68.09**
	Medical Problem(s)	xxx
E&M:	Preventive Medicine	**99385-99397**
CPT:	N/A	

7.1.i. **Scenario #9:** Patient presents with a post ACL repair. Provider does not perform an exam. A PRT waiver is issued.

Coding:		
ICD-9-CM:	Physical Readiness Test (PRT) Eval	**V70.5_C**
	Medical Problem(s)	XXX
E&M:	Other Preventive Medicine	**99420**
CPT:	N/A	

7.1.j. **Scenario #10:** Patient in scenario #7 is referred for additional assessment, face-to-face with privileged provider based upon answers on PRT questionnaire. Provider reviews assessment and determines patient is cleared for PRT.

Coding:		
ICD-9-CM:	Physical Readiness Test (PRT) Eval	**V70.5_C**
	Medical Problem(s)	xxx.xx
E&M:	Other Preventive Medicine	**99420**
CPT:	N/A	

8. Evaluation and Management Office Services: History Component

Chief Complaint - *Reason for the visit*

History of Present Illness (HPI) *is a chronological description of the development of the patient's present illness from the first sign and /or symptom or from the previous encounter to the present.*

Injury, Illness, and/or Pain

1 – Location (where, radiation from-to)
2 – Quality (sharp, burning, dull, color)
3 – Severity (scale 1-10, severe, progressive)
4 – Duration (length of time)
5 – Timing (start, steady, intermit, constant)
6 – Context (causation, activity at onset)
7– Modifying Factors what helps, worsens, relieves)
8 – Associated Signs & Symptoms (swelling, nausea, vomiting)

Review of Systems (ROS) *is an inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms which the patient may be experiencing or may have experienced.*

1 - Constitutional (fatigue, weight loss, fever, chills, sweats)
2 - Integumentary (rash, itch color change, infections nail changes)
3 - Eyes (vision, glasses, contact lenses, dryness, redness, glaucoma)
4 - ENT/Mouth (hearing, pain, bleeding, sinusitis, soreness, hoarseness)
5 - Cardiovascular (chest pain, dyspnea, palpitations, heart murmur)
6 - Respiratory (cough, wheezing, asthma, sputum – color/frequency)
7 - Gastrointestinal (nausea, vomiting, diarrhea, heartburn, constipation)
8 - Genitourinary (hematuria, frequency, burning, polyuria, incontinence)
9 - Musculoskeletal (cramps, joint pain, weakness, atrophy)
10 - Neurologic (headache, syncope, seizures, vertigo, dizziness, ataxia)
11 - Hematologic/Lymphatic (anemia, bleeding, lymphadenopathy)
12 - Endocrine (heat or cold intolerance, weight change, diabetes)
13 - Psychiatric (anxiety, sleep disturbances, memory loss, emotional instability)
14 - Allergic/Immunologic (allergies to medicine, food, dye; hepatitis, HIV)

Past, Family, Social History (PFSH) includes:

Past History - Allergies, current medications, prior hospitalizations/illness/injuries
Social History- Marital status, current employment, use of drugs, alcohol, and tobacco

Table 8.1 Calculating the History Level

Level of History	HPI	ROS	PFSH
PF (Problem Focused)	1 - 3	N/A	N/A
EPF (Expanded Problem Focused)	1 - 3	1	N/A
D (Detailed)	4+ or 3 chronic & inactive conditions	2 - 9	1 From Any
C (Comprehensive)	4+ or 3 chronic & inactive conditions	10 - 14	! From Each

9. Evaluation and Management Office Services: Physical Examination Component

1997 MULTISYSTEM EXAMINATION – Elements listed under Organ Systems and Body Areas.

Constitutional
Three of seven vital signs (BP, pulse, resp, temp, ht, wgt)
General appearance
Eyes
Inspection of conjunctivae and lids
Examination of pupils and irises (PERRLA)
Ophthalmoscopic examination of discs and posterior segments
Ears, Nose, Mouth, and Throat
External appearance of the ears and nose
Otoscopic exam of the external auditory canals and TMs
Assessment of hearing
Inspection of nasal mucosa, septum and turbinates
Inspection of lips, teeth and gums
Examination of oropharynx: oral mucosa, salivary glands, hard and soft palates, tongue, tonsils and posterior pharynx
Neck
Exam of neck (masses, symmetry, tracheal position, crepitus)
Examination of thyroid (masses, nodules, tenderness)
Respiratory
Assessment of respiratory effort
Percussion of chest
Palpation of chest (tactile fremitus)
Auscultation of the lungs
Chest (Breasts)
Inspection of the breasts
Palpation of the breasts and axillae
Cardiovascular
Palpation of the heart (PMI)
Auscultation of the heart
Assessment of lower extremity edema
Examination of the carotid arteries
Examination of abdominal aorta
Examination of the femoral pulses
Examination of the pedal pulses
G**astrointestinal (Abdomen)**
Examination of the abdomen (masses or tenderness)
Examination of the liver and spleen
Examination for the presence or absence of hernias
Examination of anus, perineum, and rectum
Obtain stool for occult blood testing if indicated
Genitourinary (Male)
Examination of the scrotal contents (tenderness of cord, testicular mass)
Examination of the penis
Digital rectal examination of the prostate

Genitourinary (Female)
Examination of the external genitalia
Examination of the urethra
Examination of the bladder (fullness, masses, tenderness)
Examination of the cervix
Examination of the uterus (size, contour, position, mobility)
Examination of the adnexa (masses, tenderness, nodularity)
Lymphatic: Palpation of lymph nodes in **two** or more areas:
Neck Groin Axillae Other (e.g. extremities)
Skin
Inspection of skin and subcutaneous tissue (rashes, lesions, ulcers)
Palpation of the skin and subcutaneous tissue (induration, subcutaneous nodules, tightening)
Musculoskeletal
Examination of gait and station
Inspection and/or palpation of digits and nails (clubbing, cyanosis, ischemia)
Examination of the joints, bones, and muscles of one or more of the following six areas:

1) Head and neck	4) Left upper extremity
2) Spine, ribs, and pelvis	5) Right lower extremity
3) Right upper extremity	6) Left lower extremity

The examination of a given area may include:
Inspection and/or palpation with notation of presence of any misalignment, asymmetry, crepitation, defects, tenderness, masses or effusions
Assessment of range of motion with notation of any pain, crepitation or contracture
Assessment of stability with notation of any dislocation, subluxation, or laxity
Assessment of muscle strength and tone with notation of any atrophy or abnormal movements
Neurologic
Test cranial nerves with notation of any deficits
Examination of DTRs with notation of abnormal reflexes
Examination of sensation (touch, pin-prick, vibration, proprioception)
Psychiatric
Description of patient's judgment and insight
Brief assessment of mental status, which may include:
Orientation to time, place, and person
Recent and remote memory
Mood and affect

Four Examination levels:	**# of Required Elements**
Problem Focused	1 - 5
Expanded Problem Focused	6 – 11
Detailed	12 - 17
Comprehensive	18 + or 2 bullets in 9 BA/OS

10. Evaluation and Management Office Services: Medical Decision Making Component

10.1. Measuring Medical Decision Making

10.1.a. Medical Decision Making is measured by the number of and/or management options that must be considered (Problem Points), the amount and/or complexity of data reviewed (Data Points), and the risk of complications, morbidity, and/or mortality, and co-morbidities (Table of Risk).

Problems Points	**# of Points**
Self-limited or minor (max of 2)	1
Established problem, stable or improving	1
Established problem, worsening	2
New problem, no work-up planned (max of 1)	3
New problem, with additional work-up planned	4

Data Reviewed Points	**# of Points**
Review/order clinical lab tests	1
Review/order x-rays (except heart cath or echo)	1
Review/order medical tests (PFTs, EKG, echo, cath)	1
Discuss test with performing physician	2
Independent review of image, tracing, or specimen	2
Decision to obtain old records	1
Review and summation of old records	2

Risk Level – Reference "Table of Risk" on next page
Stratify risk based on presenting problems, diagnostic procedures or management options selected on table of risk. It only takes one item to qualify for a level of risk. Use highest risk present on table.

Overall Complexity of Medical Decision Making is calculated by number of Problem Points, Data Points and the level of Risk below.

Medical Decision Making	**Problem Pts**	**Data Pts**	**Risk**
Straightforward	1	1	Minimal
Low	2	2	Low
Moderate	3	3	Moderate
High	4	4	High

***Two** out of **three** qualifying components are required for any given level*

Time- Specific times expressed in the visit code descriptors are averages, and therefore represent a range of times which may be higher or lower depending on the actual clinical circumstances.
Time is used when **counseling and/or coordination of care** dominates greater than 50% of the face-to-face time a provider spends with the patient and/or family (caregiver). Detailed documentation must indicate specifics on the counseling or coordination of care, discussion why the additional time was necessary, what occurred during the additional time, and how much time was spent. *Note:* The statement "Discussed: Diagnosis, Medication(s)/Treatment(s), Potential Side Effects with Patient who indicated understanding" is not acceptable documentation in and of itself (*2013 MHS Coding GLS 3.1.5.2)*.

Table 10.1 Table of Risk

Type of Medical Decision	Number of diagnoses and/or risk of complications	Diagnostic procedures/tests ordered and/or amount of data to be obtained or reviewed	Management options selected
Minimal	• One self-limited or minor problem: contusion, insect bite, tinea corporis	• Laboratory test requiring venipuncture • Chest x-rays, ECG/EEG • Urinalysis • Ultrasound	• Rest, Gargles • Elastic bandages, superficial dressings
Low	• One or two self-limited problem(s) or symptom(s) • One stable chronic illness or problem • Acute self-limited uncomplicated illness or injury • Risk of complications, morbidity or mortality is low	• Non-invasive or minimally invasive lab tests (urinalysis, venipuncture, KOH, etc) • Non-invasive diagnostic procedures (EEG, ECG, ultrasound, echocardiogram) • Physiologic tests not under stress • Non-cardiovascular imaging studies without IV or intrathecal contrast (e.g., upper GI, barium enema) • Skin biopsy • Superficial needle biopsy • Arterial puncture	• Rest or exercise, diet, stress management • Medication management with minimal risk • Referrals not requiring detailed discussion or detailed care plan
Moderate	• Three or more self-limited problems • One or more chronic mild and/or self-limited problem(s) with ongoing activity (active problem) • Two or three stable chronic illnesses or problems requiring evaluation • Undiagnosed new illness, injury or problem with uncertain prognosis • Acute illness with systemic symptoms • Moderate risk of complications, (i.e. uncertain prognosis, or mortality)	• Physiological tests under stress • Deep needle/incisional biopsy • Interventional cardiovascular or radiologic procedure for average risk patient • Percutaneous removal of body cavity fluid • Data to be obtained/reviewed requiring at least 10 minutes of physician time • IV contrast imaging • Therapeutic or diagnostic spinal/nerve injections	• Referrals requiring detailed discussion or detailed care plan • Management of medications with moderate risk (e.g., digoxin, warfarin) • Discussion for psychotherapy and/or counseling • Arranging hospitalization for noncritical illness/injury • Referral for comprehensive pain management rehabilitation

Type of Medical Decision	Number of diagnoses and/or risk of complications	Diagnostic procedures/tests ordered and/or amount of data to be obtained or reviewed	Management options selected
High	• One or more acute or chronic severe illnesses with ongoing activity • Four or more stable chronic illnesses requiring evaluation • Acute complicated injury • At least one problem posing imminent threat to life or bodily function • Abrupt change in bodily function (e.g., seizure, CVA, acute mental status change) • High risk of complications, morbidity, or mortality (possibility of significant prolonged functional impairment)	• Intra-arterial cerebral angiography (excludes MRA) • Data to be obtained/reviewed requiring at least 20 minutes of physician time • Endoscopy for high risk patient (e.g., therapeutic endoscopy for bleeding, unstable vital signs, critical illness) • Interventional cardiovascular or radiologic procedure for high risk patient (e.g., unstable condition)	• Emergency hospitalization • Medications requiring intensive monitoring (e.g., initiation of IV heparin, IV antiarrhythmics; antineoplastics) • Surgery or procedure with higher risk status • Decision not to resuscitate or to de-escalate care because of poor prognosis • Mechanical ventilator management

11. Evaluation and Management Office Services: Final E&M Selection

Table 11.1 New Patient Office Visits

E&M Code	History	Physical Exam	Medical Decision Making	Average Time (minutes)
99201	PF	PF	S	10
99202	EPF	EPF	S	20
99203	D	D	L	30
99204	C	C	M	45
99205	C	C	H	60

Table 11.2 Established patient Office Visits

E&M Code	History	Physical Exam	Medical Decision Making	Average Time (minutes)
99211	N/A	N/A	N/A	5
99212	PF	PF	S	10
99213	EPF	EPF	L	15
99214	D	D	M	25
99215	C	C	H	40

Key:

PF - Problem Focused

EPF – Expanded Problem Focused

D – Detailed

M – Moderate

C – Comprehensive

H - High

12. Coding OEM Exams

Table 12.1 Coding OEM Exams

OH Exam Type	Description	Diagnosis (ICD-9-CM Code)	Primary E&M Code	Secondary E&M Code	Procedure (CPT) Code(s)
Surveillance	Surveillance exams from Sections 4-6 of Matrix (excludes exams below)	**Primary** **V70.5_3** **Secondary** **V15 series** describing stressor	**New Patient** **99385** (18-39) **99386** (40-64) **99387** (65+) **Established Patient** **99395** (18-39) **99396** (40-64) **99397** (65+)	**99406-25** Smoking Cessation (3-10) **99407-25** Smoking Cessation (11+) **Extensive Record Review** **99358** for 1st hour + **99359** each additional ½ hour	**G0102** Prostate Screening; digital rectal **93000** EKG w/ interp **93005** EKG w/o interp **94010** Spirometry **99172/3** Snellen Chart **36415** Venipuncture
Certification	Respirator, Food Service, Childcare Worker (Matrix 700 series except exams directly below)	**Primary** **V68.09** **Secondary** Diagnosis codes for pertinent medical problems			
Vehicle Exam	Commercial Driver, Explosive Handler/ Vehicle Operator, Forklift, Weight Handling Equipment Operator	**Primary** **V70.5_3** **Secondary** Diagnosis codes for pertinent medical problems			
Fitness for Duty/ Suitability	Evaluation of worker to assess fitness to return to work	**Primary** **V70.5_7** **Secondary** Diagnosis codes for pertinent medical problems			
Disability Evaluation	Evaluation leading to impairment/disability rating (Usually complex, detailed)	**Primary** **V70.3** **Secondary** Diagnosis codes for pertinent medical problems	**Treating provider** **99455** **Other than treating provider** **99456**		
Reproductive Toxicity Evaluation	Assessing/communicating reproductive risks in a job	**Primary** **V70.5_7** **Secondary** **V22.2** (Pregnant)			N/A
Hearing Loss Medical Evaluation	Evaluation for work-relatedness and/or impairment	**Primary** **V70.5_7** **Secondary** Diagnosis codes for pertinent medical problems	**New Patient** **99385** (18-39) **99386** (40-64) **99387** (65+) **Established Patient** **99395** (18-39) **99396** (40-64) **99397** (65+)		
Military Physical Exam	Military physicals including PEB exams (Not separation/ retirement)	**Primary** **V70.5_0** (Periodic Exam) **V70.5_1** (Flight Physical; or **V70.5_7** (PEB Exam) **Secondary**			**G0102** Prostate

OH Exam Type	Description	Diagnosis (ICD-9-CM Code)	Primary E&M Code	Secondary E&M Code	Procedure (CPT) Code(s)
		Diagnosis codes for pertinent medical problems			Screening; digital rectal **93000** EKG w/ interp **93005** EKG w/o interp **94010** Spirometry **99172/3** Snellen Chart **36415** Venipuncture
Military Separation or Retirement Exam	Self-explanatory	**Primary** **V70.5_9** **Secondary** Diagnosis codes for pertinent medical problems			
MSC physical Exam	Military Sealift Command pre-employment or periodic exams	**Primary** **V70.5_3** (Pre-employment) **V70.5_2** (Periodic) **Secondary** Diagnosis codes for pertinent medical problems		**New Patient** **99201-25** (PF 10 min) **99202-25** (EPF 20 min) **99203-25** (D 30 min) **99204-25** (C 45 min) **99205-25** (C 60 min) **Established Patient** **99212-25** (PF 10 min) **99213-25** (EPF 15 min) **99214-25** (D 25 min) **99215-25** (C 40 min) **99406-25** Smoking Cessation (3-10) **99407-25** Smoking Cessation (11+)	
Deployment Screening	Military pre- and post-deployment assessments	**Primary** **V70.5_4** (Pre-employment) **V70.5_6** (Post-deployment) **Secondary** Diagnosis codes for pertinent medical problems			
Special Case – Combined Problem and Preventive Visit	Patient appointment for preventive exam, medical problem(s) requiring additional evaluation & management addressed	**Primary** **V70.5_X** **Secondary** Diagnosis codes for pertinent medical problems			
Acute Care Visit	Patient problem possibly work-related	**Primary** Diagnosis code(s) pertinent to current visit **Secondary** E-codes describing cause and place of injuries	**New Patient** **99201** (PF 10 min) **99202** (EPF 20 min) **99203** (D 30 min) **99204** (C 45 min) 99205 (C 60 min) **Established Patient** **99212** (PF 10 min) **99213** (EPF 15 min) **99214** (D 25 min) **99215** (C 40 min)	Extensive Face-to-Face **99354** for 1st hour **99355** each additional ½ hour **99406-25** Smoking	
Asbestos CXR F/U	Visit for follow-up of abnormal asbestos surveillance CXR	**Confirmed Asbestosis 501** **Non-Specific CXR finding**			

OH Exam Type	Description	Diagnosis (ICD-9-CM Code)	Primary E&M Code	Secondary E&M Code	Procedure (CPT) Code(s)
		793.1		Cessation (3-10) **99407-25** Smoking Cessation (11+)	
Multiple Exams in same category	For example, multiple vehicular-type exams (e.g., DOT and forklift) Complicated – only use same V-code once.	**Primary** **V70.5_X** **Secondary** Diagnosis codes for pertinent problems	**New Patient** **99385** (18-39) **99386** (40-64) **99387** (65+) **Established Patient** **99395** (18-39) **99396** (40-64) **99397** (65+)		**G0102** Prostate Screening; digital rectal **93000** EKG w/ interp **93005** EKG w/o interp **94010** Spirometry **99172/3** Snellen Chart **36415** Venipuncture

13. Abbreviations

AMA – American Medical Association
CPT – Current Procedural Terminology
DoD – Department of Defense
HCPCS – Healthcare Common Procedural Coding System
HPI – History of Present Illness
ICD-9-CM – International Classification of Disease – 9th Revision – Clinical Modification
ICD-10-CM - International Classification of Disease – 10th Revision – Clinical Modification
MDM – Medical Decision Making
MHS – Military Healthcare System
MTF – Military Treatment Facility
OEM – Occupational Environmental Medicine
PFSHx – Past, Family, and Social History
ROS – Review of Systems
VAERS – Vaccine Adverse Event Reporting System

14. References

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