

THE CODING BOOK
FOR
MILITARY OCCUPATIONAL
AND
ENVIRONMENTAL MEDICINE

Version 3

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CHAPTER 1: BASIC CONCEPTS OF CODING

1-1. FROM RECORDING WORKLOAD TO IDENTIFYING SERVICES

- a. In the past, workload measured by number of patient visits was the basis for reimbursement of the military treatment facilities (MTFs). Reimbursement now depends on identifying the services provided to the patient rather than a simple count of visits.
- b. The military has adopted coding systems from the civilian sector for identifying services provided by its clinics. Policy requires that military clinics use these codes in the same manner as their civilian counterparts. The [Military Health System Coding Guidance](#) supplements these coding systems with military-specific direction and takes precedence over them in the event of conflicting guidance.
- c. Inaccurate coding in both military and civilian clinics can lead to penalties. “Overcoding” (i.e., coding for services beyond those provided) constitutes fraud. “Undercoding” leads to lower reimbursement. **Documentation in the patient record must substantiate the codes selected.**

1-2. CODING SYSTEMS

- a. The International Classification of Disease, 9th Revision - Clinical Modification (ICD-9-CM) is the diagnostic coding system describing why the practice provided services to the patient, thereby establishing the medical necessity of the care provided. The ICD-9-CM is updated annually on 1 October. A three-digit code represents the general diagnosis, with up to two additional digits after the decimal point adding additional detail. The first step in identifying the services provided to a patient is to establish the medical necessity of the visit through ICD-9-CM diagnostic coding.
- b. The Healthcare Common Procedure Coding System (HCPCS) Level I, commonly known as Current Procedural Terminology (CPT), is the coding system describing the services and procedures provided to the patient. Updates to CPT occur annually on 1 January. CPT codes are five digits and can further describe or explain services rendered by adding modifiers to the basic five-digit code when appropriate. 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.
- c. The Healthcare Common Procedure Coding System (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 in coding a visit. Proper coding of HCPCS Level II codes captures all practice expense so that clinics can be budgeted adequately each year to meet their patient demands.

1-3. REIMBURSEMENT AND WORKLOAD CREDIT

- 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 \$72 reimbursement to the MTF, depending on specialty.
- b. The mechanism by which a military clinic submits its “claim” for reimbursement for outpatient care is entry of ICD-9-CM, CPT, and HCPCS Level II codes describing the patient encounter in the Armed Forces Health Longitudinal Technology Application (AHLTA) by the provider. The billing system (TPOCS) then transfers this information from AHLTA onto a CMS-1500 Medical Claim Form for payment by the appropriate insurance company.

c. Coding is important to military providers for several reasons. First, the MTF relies on coding by the providers to collect reimbursement from individuals who have other health insurance (including those employed by other Federal agencies). Second, under the prospective payment system, MTFs receive funding based solely on what services they have provided (as documented by coding) in the previous fiscal year. Third, workload credit in the form of RVUs can provide input for performance evaluations (e.g., FITREPs). Finally, accurate ICD-9-CM codes have applications reaching beyond financial reimbursement to epidemiologic analysis and prevention.

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	https://dq.med.navy.mil/default.htm

CHAPTER TWO: ICD-9-CM DIAGNOSTIC CODING

2-1. INJURY AND ILLNESS CODING

- a. ICD-9-CM coding for evaluation and treatment of acute injuries and illnesses in an OEM practice 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 2-1 lists some ICD-9-CM codes commonly used in occupational health clinics.
- b. Use only the ICD-9-CM code for the condition that prompted the workers' visit, regardless of other chronic conditions that may be present. As an example, consider an employee under treatment for essential hypertension who sustains a laceration to the finger. The reason for the visit to the OEM clinic is the laceration (coded as 883.0 under category Open Wound). The OEM provider should code only 883.0 in AHLTA. The laceration, **not** essential hypertension, resulted in provision of services to this employee. In contrast, a primary care clinic may also code for essential hypertension **if** blood pressure is measured, adequacy of treatment reassessed, and this reassessment is documented during the visit.
- 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 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 visits.
- 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. To use the coding manual, start with the alphabetic index (Volume 2) 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.)
- e. If an employee has signs and symptoms but no diagnosis yet, refer to Section 16 of the ICD-9-CM book titled, "Signs, Symptoms, and Ill-Defined Conditions." Use of these codes is as 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.

Table 2- 1: ICD-9-CM Codes Commonly Used in OEM

Signs and Symptoms					
		486	Pneumonia, unspecified	984.1	Toxic effects of Organic lead
789.00	Abdominal Pain Unspecified	518.89	Pulmonary Nodule NEC Lung Disease	984.8	Toxic effects of Other lead
781.2	Abnormal Gait	780.39	Seizure Disorder NOS	**985.8	Toxic effects of Thallium
477.9	Allergic Rhinitis	786.05	Shortness of Breath	983.9	Toxic effects of Unspecified caustic
786.2	Cough	719.41	Shoulder Joint Pain	**984.9	Toxic effects of Unspecified lead
780.6	Fever	729.81	Swelling in Limbs	985.9	Toxic effects of Unspecified metals
784.0	Headache	780.02	Transient Alteration of Awareness	989.5	Toxic effects of Venom
724.2	Low Back Pain	401.9	Unspecified HTN	923.21	Wrist, Contusion
782.0	Numbness	599.0	Urinary Tract Infection, unspecified		
278.00	Obesity, unspecified	787.01	Vomiting w/ Nausea		Spine and Back
305.1	Tobacco Use Disorder	719.43	Wrist (Forearm Joint) Pain	739.9	Abdomen & Other Sites Somatic Dys
V15.82	Tobacco Use History			739.1	Cervical Somatic Dysfunction
465.9	Acute URI NOS	Other: _____		724.6	Disorder of the Sacrum
305.01	Alcohol Abuse, Continuous Use			739.0	Head Somatic Dysfunction
780.97	Altered Mental Status			739.6	Lower Ext Somatic Dysfunction
285.9	Anemia, Unspecified			739.3	Lumbar Somatic Dysfunction
719.47	Ankle (Foot Joint) Pain			733.90	Osteopenia
300.00	Anxiety State, unspecified			733.00	Osteoporosis, unspecified
401.1	Benign Essential HTN	915.0	Abrasion/Friction Burn, Finger	739.5	Pelvic Somatic Dysfunction
786.50	Chest Pain, unspecified	924.21	Ankle, Contusion	739.8	Rib Cage Somatic Dysfunction
276.51	Dehydration	871.3	Avulsion of eye	739.4	Sacral Somatic Dysfunction
V58.67	Diabetes - Long Term Insulin Use	924.20	Black Heel	724.3	Sciatica
250.01	Diabetes Type I, Controlled	923.20	Black Palm	737.30	Scoliosis, Idiopathic
250.00	Diabetes Type II, Controlled	921.0	Blackeye, NOS	724.8	Symptoms of the Back
780.4	Dizziness/vertigo, nos	930.0	Corneal Foreign Body	724.1	Thoracic Pain
715.09	DJD - Multiple Sites	931	Ear Foreign Body	739.2	Thoracic Somatic Dysfunction
305.91	Drug Abuse, Continuous, Unsp	923.11	Elbow, Contusion	724.4	Thoracic/Lumbosacral Radiculitis, unsp
787.91	Diarrhea NOS	959.3	Elbow/Forearm/Wrist Injury	724.9	Unspecified Back Disorder
787.2	Dysphagia	921.9	Eye, Contusion/Injury, Unspecified	724.5	Unspecified Back Pain
782.3	Edema	959.09	Face/Neck Injury Unspecified	739.7	Upper Ext Somatic Dysfunction
719.42	Elbow (Upper Arm Joint) Pain	920	Face/Scalp (except eyes) Contusion		
796.2	Elevated BP w/o dx HTN	923.3	Finger, Contusion		Sprains and Strains
492.8	Emphysema NOS	923.10	Forearm, Contusion	845.00	Ankle, unspecified
719.44	Finger (Hand Joint) Pain	873.42	Forehead/Eyebrow Laceration	847.9	Back, unspecified
780.96	Generalized Pain	959.01	Head Injury Unspecified	845.01	Deltoid Ligament, Ankle
530.81	GERD	924.01	Hip, Contusion	841.8	Elbow/Forearm, specified
346.90	Headache, Migraine, unspecified	924.11	Knee, Contusion	841.9	Elbow/Forearm, unspecified
307.81	Headache, Tension	959.7	Knee/Leg/Ankle/Foot Injury	845.10	Foot, unspecified
719.45	Hip (Pelvic Region Joint) Pain	924.10	Lower Leg, Contusion	842.10	Hand, unspecified
V65.43	Injury Prevention Counseling	932	Nose Foreign Body	843.9	Hip/Thigh, unspecified
719.49	Joint Pain, Multiple Sites	873.1	Scalp, laceration complicated	844.2	Knee, Cruciate Ligament
719.46	Knee (Lower Leg Joint) Pain	873.0	Scalp, laceration uncomplicated	844.8	Knee/Leg, Other specified
780.79	Malaise / Fatigue / Weakness	923.00	Shoulder, Contusion	844.9	Knee/Leg, unspecified
401.0	Malignant Essential HTN	959.2	Shoulder/Upper Arm Injury	844.0	Lateral Collateral Knee Ligament
787.02	Nausea Alone	733.94	Stress Fracture Metatarsals	847.2	Lumbar Spine
V65.3	Nutritional Counseling	733.95	Stress fracture other bone	844.1	Medial Collateral Knee Ligament
786.02	Orthopnea	733.93	Stress fracture tibia/fibula	845.12	Metatarsophalangeal (joint)
715.90	Osteoarthritis Unspecified	924.00	Thigh, contusion	847.0	Neck (whiplash injury)
729.5	Pain in limb, axillary	924.3	Toe, contusion (Talon Noir)	846.9	Sacroiliac Region, unspecified
300.01	Panic disorder	983.1	Toxic effects of acid	847.3	Sacrum (Sacrococcygeal ligament)
462	Pharyngitis, acute	985.1	Toxic effects of arsenic	840.9	Shoulder/Upper Arm, unspecified
		986	Toxic effects of carbon monoxide	848.1	Temporomandibular (joint/ligament)
		983.0	Toxic effects of corrosive aromatics	847.1	Thoracic Spine
		984.0	Toxic effects of inorganic lead	842.00	Wrist, unspecified
		**985.0	Toxic effects of mercury		

* Remember to use E codes (See Table 2-2)

** Use secondary diagnosis code 323.71

2-2. E CODES

- a. For external causes of injury, poisoning and adverse reactions, the ICD-9-CM classification contains 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 means a puncture wound to the finger (883.0) due to a hypodermic needle (E920.5).
- b. Use E-codes only during the first patient visit for an injury, not for follow-up visits UNLESS the injury is war-related. For war-related injuries, the E-code is used at all follow-up visits.
- c. AHLTA requires entry of E codes for ICD-9-CM codes recognized as injury diagnoses. Chapter Five contains more information on entry of E codes in AHLTA.
- d. The ICD-9-CM codebook contains a section on E codes at the end of the alphabetic index, Volume 2. Like the numeric codes, E codes have a hierarchical organization. Table 2-2 contains frequently used E-codes in OEM.
- 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 2- 2: E 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 or other opening	E883.9
Accident by Hot Substance/Object	E924.8	Fall-slipping, tripping & stumbling	E885.9
Accidental Poisoning by Arsenic	E866.3	Foreign body in eye & adnexa	E914
Accidental Poisoning by Lead	E866.0	Hornet, wasp & bee stings	E905.3
Accidental Poisoning by Mercury	E866.1	Human Bite	E928.3
Accidental Poisoning by Metals	E866.4	Hypodermic needlestick accident	E920.5
Cause-Electric Current	E925.1	Lifting machine & appliance	E919.2
Cause-Other Hand Tools/Implement	E920.4	Metalworking 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 (PVC) bldg/structure	E891.1	Other specified machinery	E919.8
Conflagration, other accident bldg/structure	E891.8	Overexert/strenuous mvmt 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 accidentally by falling object	E916
Exposure to noise pollution	E928.1	Vibration	E928.2

WAR Related E Codes

Injury due to war ops 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 antipersonnel bomb	E991.3
Injury due to war ops from unspecified fragments	E991.9	Injury due to war ops from unspecified source	E990.9
Injury due to war ops by explosion of marine weapons	E992	Injury due to war ops by explosion	E993
Injury due to war ops by destruction of aircraft	E994	Injury due to war ops by unspecified forms	E995
Injury due to war ops by nuclear weapons	E996	Injury due to war ops but occurring after cessation of hostilities	E998
Injury due to war ops from gasoline bomb	E990.0	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

2-3. V CODES

a. OEM services frequently provide care to workers without specific symptoms or diagnoses, such as medical surveillance or job certification exams. 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.

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.

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.

(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 a pre-deployment health assessment (see Table 2-3).

(2) **V68.09** encounters are for administrative purposes such as the issuance of a medical certification, 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.

Table 2- 3: DoD Extenders for V70.5

Extender	Purpose	Description
V70.5_0	Armed Forces Medical Exam	Pre-enlistment general exam
V70.5_1	Aviation exam	
V70.5_2	Periodic Health Assessments	
V70.5_3	Occupational exam	Includes initial certifying and recurring exams
V70.5_4	Pre-deployment related encounter	Not Pre-deployment assessment
V70.5_5	Intra-deployment related encounter	
V70.5_6	Post-deployment related encounter	
V70.5_7	Duty status determination	Includes return to work and disability evaluation
V70.5_8	Special Program Accession encounter	Prior to 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 Reassessment	Identified conditions are secondary codes
V68.09	Issuance of Medial Certificate	Use only as primary code, do not use in conjunction with V70.x

d. Visits including preventive counseling and education, such as a reproductive hazard evaluations, also require V codes to describe medical necessity of the education or counseling provided. These codes are secondary codes to the appropriate primary diagnostic or V codes. Table 2-4 provides some helpful secondary V codes for describing these visits.

Table 2- 4: 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

e. Table 2-5 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. 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 2- 5: V Codes for Hearing Conservation Program Exams

Encounter Type	ICD-9-CM Codes
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, nurses, volunteers). Physicians or audiologists may diagnose noise-induced hearing loss.

f. For individuals receiving occupational audiology evaluation after an abnormal screening evaluation, V code extenders in Table 2-6 apply.

Table 2- 6: V 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

g. For individuals receiving immunizations as required by medical surveillance, V codes in Table 2-7 apply.

Table 2-7: V Codes for Immunizations

IMMUNIZATIONS Vaccine or Medication Name	Admin CPT	CPT HCPCS	ICD9	
Anthrax	90471 / 2	90581	V03.89	
B-12	90772	J3420	266.2 or per Dr order	
Chicken Pox(Varivax) Varicella	90471 / 2	90716	V05.4	
Depo Provera 150mg	90772	J1055	V25.49	

Depo Provera 50mg	90772	J1051	Per Dr order	
DTaP < 7 years	90471 / 2	90700	V06.1	
DT, Pediatric, <7 years	90471 / 2	90702	V06.5	
Flu Shot, split virus 6-35 months of age	90471 / 2	90657	V04.81	
Flu Shot , split virus >3 years	90471 / 2	90658	V04.81	
Flu Mist (intranasal)	90473	90660	V04.81	
Hep A, 1-18 yrs, 2 Dose Sch.	90471 / 2	90633	V05.3	
Hep A, Adult	90471 / 2	90632	V05.3	
Hep B, 0-19 years, 3 Dose Sch.	90471 / 2	90744	V05.3	
Hep B, Adult, 20+	90471 / 2	90746	V05.3	
HPV – Gardasil V04.89	90471 / 2	90649	V05.8	
Twinrix, Hep A & Hep B, adult	90471 / 2	90636	V06.8	
HIB (3 dose vaccine) PRP-OMP	90471 / 2	90647	V03.81	
IPV (Polio) IM or SUBQ	90471 / 2	90713	V04.0	
JEV (Japanese Encephalitis Virus)	90471 / 2	90735	V05.0	
Meningococcal (2-10 yrs old) Menemune	90471 / 2	90733	V03.89	
Meningococcal (10 yrs/ older) Menactra con	90471 / 2	90734	V03.89	
MMR	90471 / 2	90707	V06.4	
MMRV (ProQuad)	90471 / 2	90710	V06.8	
Pediarix (DTaP, IPV, Hep B)	90471 / 2	90723	V06.8	
Pneumoccal, conj. <5 years	90471 / 2	90669	V03.82	
Pneumovax, Adult or immunosuppressed patient	90471 / 2	90732	V03.82	
PPD Placement (TB test)	-----	86580	V74.1	
PPD – Read NEGATIVE	-----	-----	V74.1	
PPD—Read POSITIVE			795.5	
Rabies IM	90471 / 2	90675	V04.5	
Rotavirus 3 dose sched., live, for Oral use	90473	90680	V04.89	
Synagist (per 100mg vial)	90772	90378	V04.82	
Td, Adult >7	90471 / 2	90718	V06.5	
Tdap IM > 7 years and older V06.1	90471 / 2	90715	V06.8	
Tetanus toxoid	90471 / 2	90703	V03.7	
Typhoid IM (ViCpS)	90471 / 2	90691	V03.1	
Typhoid Oral	90473	90690	V03.1	
Yellow Fever	90471 / 2	90717	V04.4	
Zoster (Shingles) SUBQ	90471 / 2	90736	V05.8	
PRESERVATIVE FREE (PF)				
Flu Shot, split virus 6-35 months of age, PF	90471 / 2	90655	V04.81	
Flu Shot, split virus >3, PF	90471 / 2	90656	V04.81	
Tetanus and Diphtheria toxoids(Td) age >7, PF	90471 / 2	90714	V06.5	
*** Administration codes*** if inj and oral/nasal given concurrent always list inject first. If you administer more than one each additional injectable would be coded as a 90472				
Use 90473 if you give an oral or a nasal with NO OTHER VACCINE				
If you administer more than one oral or nasal then ADD 90474				
IMMUNE GLOBULINS				
Immune Globulin (Ig) IM	90772	90281	V04.89	
Respiratory syncytial virus immune globulin (RSV-IgIM) PER UNIT 50mg each	90772	90378	V04.82	
Tetanus Immune Globulin (Tig)IM 01 PFS	90772	90389	V03.89	
Rabies Immune Globulin (Rig-HT), HT 10 1vi	90772	90376	V04.5	
SHOT TRANSCRIPTION ON TO SPECIAL FORM – such as PH731/State SchPE Form etc.				
Special Reports / Forms		99080	V68.09	
SMALLPOX VACCINE				
<i>*only given at NMCP, Boone and Sewells Point</i>				
Smallpox	\$202/vial	90471 / 2	V04.1	
Dr. supervised Grp Edu Svsc (DOD required briefing)				
Dr. supervised Provision Edu Supplies (Mandatory Tri-fold)		99071		
Dr. service: smallpox review/reporting of status (scrn form clearance w/ reporting)		99071		
Special Foam Dressing, wound cover, 16 sq. inch or less, adhes (per unit – usually 6 given –)		A6212		
Purell		99070		
Other Therapies; Non-MD Patient Education and Counseling Non-MD Instruction for Patients		S9445		
ADVERSE EFFECTS – Nurses use if initiating VAERS		99071		
Special Reporting (VAERS reporting) Patient Education-Medication Adverse Event				

Diphtheria		99080	E948.5	
Mix (combination)		99080	E948.9	
Pertussis		99080	E948.6	
Tetanus		99080	E948.4	
Measles		99080	E949.4	
Lymes Vac		99080	E948.8	
Mumps		99080	E949.6	
Polio		99080	E949.5	
Rabies		99080	E949.1	
Typhoid		99080	E948.1	
Yellow fever		99080	E949.3	
Smallpox		99080	E949.0	
Bacterial, other and unspecified		99080	E948.8	
Other-unspec vaccines and biological substances		99080	E949.9	
When filing a VAERS one must use the 99080, V65.49 with the appropriate E code.				
VACCINATION REFUSAL				
Vaccination not carried out, unspecified reason		99080	V64.00	
Vaccination not carried out because of acute illness		99080	V64.01	
Vaccination not carried out because of chronic illness or condition		99080	V64.02	
Vaccination not carried out because of immune compromised state		99080	V64.03	
Vaccination not carried out because of allergy to vaccine or component		99080	V64.04	
Vaccination not carried out because of caregiver refusal		99080	V64.05	
Vaccination not carried out because of patient refusal		99080	V64.06	
Vaccination not carried out for religious reasons		99080	V64.07	
Vaccination not carried out because patient had disease being vaccinated against		99080	V64.08	
Vaccination not carried out for other reason		99080	V64.09	

CHAPTER THREE: CPT CODING FOR PRIVILEGED PROVIDER SERVICES

3-1. CATEGORIES OF E&M SERVICES PERTINENT TO OEM

a. Evaluation and management (E&M) codes are the subset of CPT codes that quantify the work done by the privileged provider during (or associated with) a patient visit. E&M codes, CPT procedure codes, and HCPCS Level II codes together determine the reimbursement for the patient visit. For specialties such as OEM that are less procedure-oriented, E&M codes are the largest contributor to reimbursement.

b. Different categories of E&M codes apply to different types of visits. Table 3-1 outlines the E&M categories pertinent to OEM clinics.

Table 3- 1: E&M Categories Used in OEM

Category/Subcategory	Code Numbers
Problem-Oriented Services <input type="checkbox"/> New Patient <input type="checkbox"/> Established Patient <input type="checkbox"/> Consultation	99201-99205 99211-99215 99241-99245
Preventive Medicine Services <input type="checkbox"/> New Patient <input type="checkbox"/> Established Patient	99381-99387 99391-99397
Preventive Medicine Counseling Services <input type="checkbox"/> Individual Counseling <input type="checkbox"/> Group Counseling	99401-99404 99411-99412
Case Management Services <input type="checkbox"/> Case Management, each 15 minutes <input type="checkbox"/> Team Conferences <input type="checkbox"/> Telephone Calls (Privileged Providers only)	T1016 99361-99362 99441-99443
Prolonged Services <input type="checkbox"/> Direct Patient Contact <input type="checkbox"/> Without Direct Patient Contact	99354-99355 99358-99359
Special Services <input type="checkbox"/> Work-Related or Medical Disability Evaluation	99455-99456*
*Precludes use of 99080 CPT procedure code	

3-2. PROBLEM-ORIENTED SERVICES

a. OEM practices that provide acute care use the same evaluation and management (E&M) codes as primary care clinics. The problem-oriented E&M codes represent five different levels of complexity based on the intensity of care. The provider, **not AHLTA**, selects the appropriate E&M code level for the patient visit. The five levels of service are minimal, problem focused, expanded problem focused, detailed, and comprehensive. Privileged providers typically do not use the minimal level unless their documentation is deficient. 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.

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.

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/coordinates time. This time does not include resident or support staff time with the patient. Prolonged time is described by the -21 modifier only for the highest level (i.e., comprehensive or 99215) E&M services, or by an additional prolonged services E&M code for other levels (see section 3-5). Reporting any code that is measured by time only must be supported within the providers' documentation by time in and time out per DoD Coding Guidelines and must also show how much time was spent directly counseling/coordinates care within the time in and time out span. (For example, time in 1300; time out 1415 – 50 minutes spent counseling/coordinates care for pt on)

d. Problem-oriented E&M codes distinguish between services provided in consultation, to a new patient, and to an established patient. New patient and consult visits receive a higher reimbursement than established patient visits for the same level of complexity. CPT defines a new patient as one who has not received any professional services from the physician (or another physician in the same practice group) within the past 3 years. New patient visits require documentation of all three key components (history, exam, and medical decision-making), whereas established patient visits require only two of the three key components.

e. **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.

f. 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. Appendix A provides expanded information on the history component. The physical exam component depends on the number of organ systems and body areas evaluated. Appendix B provides expanded information on the physical exam component. Medical decision-making complexity depends on the Table of Risk (Appendix C).

g. After determining the level of complexity for each of the three key components, find the final E&M level for the visit in Appendix D. Again, remember that the lowest complexity component drives the level of service. If three components are completed for an established patient, the E&M level is the middle complexity component (i.e., drop the lowest component since it is not required).

3-3. PREVENTIVE MEDICINE SERVICES

a. 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 coding for problem-oriented visits, preventive services codes also distinguish between new and established patients.

b. 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 3-2 provides guidance in differentiating problem-oriented, preventive medicine, and combined visits.

Table 3- 2: Differentiating Preventive Medicine Visits from Problem-Oriented Visits

	Preventive Medicine Visit	Problem-Oriented Visit	Preventive Medicine Visit with Problem
Chief complaint	Healthy patient No complaints Insignificant/trivial problem	Chief complaint specified	Healthy patient with significant complaint
History	Not problem oriented No present illness described Pertinent risk factors assessed	Limited to presenting problem	Include history related to age/gender <i>and</i> present illness
System review, Past/family/social history	Comprehensive system review, Comprehensive PFSH	Pertinent to presenting problem	Comprehensive system review/PFSH + data specific to presenting problem
Examination	Based on age, risk factors	Appropriate to presenting problem	Age and risk factor based exam + eval 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 services ordered for specific medical problem	Screening + medical decision making

c. Code diagnoses, symptoms, or signs discovered during a preventive services visit but not requiring significant time and resources as secondary ICD-9-CM codes.

3-4. PREVENTIVE MEDICINE COUNSELING SERVICES

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.

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.

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

d. ICD-9-CM codes for these encounters are V codes described in Chapter 2.

3-5. CASE MANAGEMENT SERVICES

a. Case management codes report coordination of care with other providers or employers without a patient encounter on that day. Medical team conferences by the provider with an interdisciplinary team of health professionals receive an E&M code. Note, however, that 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 comp claim).

b. Do not code site visits that are not associated with care of an individual patient. However, if the walk-through occurs in conjunction with individual patient care (e.g., to clarify reasonable

accommodation in a fitness for duty evaluation) and as part of an interdisciplinary team, case management E&M codes apply.

c. Time determines the appropriate level of case management E&M code. Code 99361 reflects a 30-minute team conference while code 99362 reflects a 60-minute team conference.

3-6. PROLONGED SERVICES

a. Prolonged provider services occur when the care provided requires at least 30 minutes more than usual. Use these secondary E&M codes **only** in conjunction with a problem-oriented, preventive service, or special service E&M code. 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.

b. Code prolonged services with direct patient contact as 99354 for 30 to 60 minutes and add 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.

3-7. SPECIAL SERVICES

a. Work-related disability examinations fall under special E&M services. These exams include a history and exam 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.

b. If the provider is treating the employee, code 99455 applies. If the provider is not treating the employee, code 99456 applies.

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

3-8. CPT PROCEDURE CODES

a. Specific procedures performed during a problem-oriented or preventive services visit receive additional CPT procedure codes (and therefore additional workload credit). 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.

b. Table 3-3 outlines some of the more common procedural codes used in conjunction with OEM problem-oriented and preventive visits.

Table 3- 3: Common CPT Procedural Codes for OEM

Procedure	Code
Problem-Oriented Visits	
Application of modality, hot or cold packs	97010
Educational Materials given to pt.	99071
IV Infusion, first hour	90765
IV Infusion, each additional hour	90766
Orthotic mgmt and training; ea 15 min	97760
Tetanus/Diphtheria Vaccine (IM)	90718

Use with Tetanus Vaccine (Admin)	90471
Venipuncture (Code Specimen Handling Also)	36415
Laceration Repair face/ear/nose/lip/eyelid; ≤2.5 cm	12001
Laceration Repair face/ear/nose/lip/eyelid; 2.6-7.5 cm	12002
Laceration Repair scalp/neck/trunk/ext; ≤2.5 cm	12011
Laceration Repair scalp/neck/trunk/ext; 2.6-5.0 cm	12013
Preventive Visits	
Venipuncture	36415
Spirometry	94010
Tympanometry	92567
Visual acuity	99173
EKG	93000 (global) 93005 (tracing only) 93010 (interpretation and report only)
Immunizations,	90465–90749
PPD placement	86580
Guaiaac Test	82270
Dip Stick Urinalysis	81002
Audiometry	Screening, Pure tone, air only, 92551 Pure tone (threshold), air only, 92552 Testing of groups, 92559

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

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. 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.

e. Table 3-4 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 3- 4: Special Procedure Codes for OEM

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

3-9. OTHER SERVICES

a. Telephone calls between a privileged provider and patient constitute episodes 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.

b. 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 code. If an audiologist evaluates a patient but performs no procedure, use problem-oriented E&M codes based on the history, exam, and medical decision-making documented in the medical record.

CHAPTER FOUR: CODES FOR SUPPORT STAFF SERVICES AND SUPPLIES

4-1. OCCUPATIONAL HEALTH NURSES AND TECHNICIANS

- 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). 99499 can also report other unique military data collection (e.g., technician review of a DD 2795).
- 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.
- 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.
- d. Add occupational health nurses and technicians involved in a patient visit as **additional providers** for that visit. This documentation supports the necessity of staff in operation of the clinic.
- e. 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
- f. CPT procedure codes for support staff include those in Table 4-1. 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 4- 1: CPT Codes for Support Staff

Description of procedure	CPT Code
Education for patient self-management by non-privileged provider	
<input type="checkbox"/> Individual	98960
<input type="checkbox"/> 2-4 Patients	98961
<input type="checkbox"/> 5-8 Patients	98962
Conveyance of specimen for transfer from provider's office to laboratory	99000
Health and behavior assessment (i.e. Needlesticks)	
<input type="checkbox"/> Initial assessment	96150
<input type="checkbox"/> Reassessment	96151
Educational Materials given to pt (by provider or support staff)	99071
Group counseling (60 min)	99412
Case Management Services	
<input type="checkbox"/> Telephone Calls (Non-Privileged Providers only)	98966-98968

4-2. HCPCS LEVEL II CODES

- 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 4-2 lists some

commonly used equipment and supplies. Again, develop consistent procedures to ensure maximal coding of services provided.

Table 4- 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
Ankle Orthosis (elastic) prefabricated	L1901	Kenalog, per 10 mg	J3301
Ankle Orthosis (pneumatic/stirrup style)	L4350	Knee Immobilizer, (canvas) prefabricated	L1830
Ankle/Foot Orthosis, static (adjustable)	L4396	Knee Orthosis (pneumatic)	L4380
Benadryl, up to 50 mg	J1200	Knee Orthosis w/ joints (elastic) prefabricated	L1810
Cane, all materials, fixed or adjustable	E0100	Leg; Walking Boot (pneumatic)	L4360
Ceftriaxone Sodium, per 250 mg (Rocephin)	J0696	Lidocaine/Marcaine Injection	J3490
Cervical Orthosis (foam collar)	L0120	Light compression bandage, elastic	A6450
Crutches, underarm, pair (not wood)	E0114	Nitroglycerin, each	J3490
Crutches, underarm, pair (wood)	E0112	Normal Saline Solution (up to 1 Liter)	J7030
Elbow Orthosis (elastic/neoprene)	L3701	Phenergan (up to 50 mg)	J2550
Elbow Orthosis; adjust. locking joints (Any type)	L3760	Ringer's Lactate (up to 1 Liter)	J7120
Finger splint, static	Q4049	Shoulder Orthosis, double shoulder (elastic)	L3652
Foot Drop Splint, Recumbent Positioning Device	L4398	Shoulder Orthosis, hard plastic, stabilizer	L3677
Full Leg Orthosis (pneumatic)	L4370	Shoulder Orthosis, single shoulder (elastic)	L3651
Gauze (non-adhesive) 16 sq. inch or less	A6216	Suture Removal Kit*	S0630
Generic Splint Supply	A4570	Toradol, per 15 mg	J1885
Hand Orthosis (metacarpal fracture orthosis)	L3917	Upper Ext Fracture Orthosis (w/ wrist)	L3984
Hand/Finger Orthosis w/o joints	L3923	Wrist Orthosis, (elastic) prefabricated	L3909
Ice Cap or Collar	E0230	Wrist/Hand/Finger Orthosis (any type)	L3911
*only if sutures done elsewhere			

b. HCPCS Level II also encompasses some privileged provider services not included in the CPT procedure codes. Table 4-3 provides some common examples.

Table 4- 3: HCPCS Level II Service Codes Commonly Used in OEM

Service	HCPCS Code
Smoking cessation counseling	
<input type="checkbox"/> 3-10 minutes	G0375
<input type="checkbox"/> 10+ minutes	G0376
Digital Rectal Exam for Prostate Cancer Screening	G0102
Pap smear collection	Q0091

CHAPTER FIVE: AHLTA AND CODING

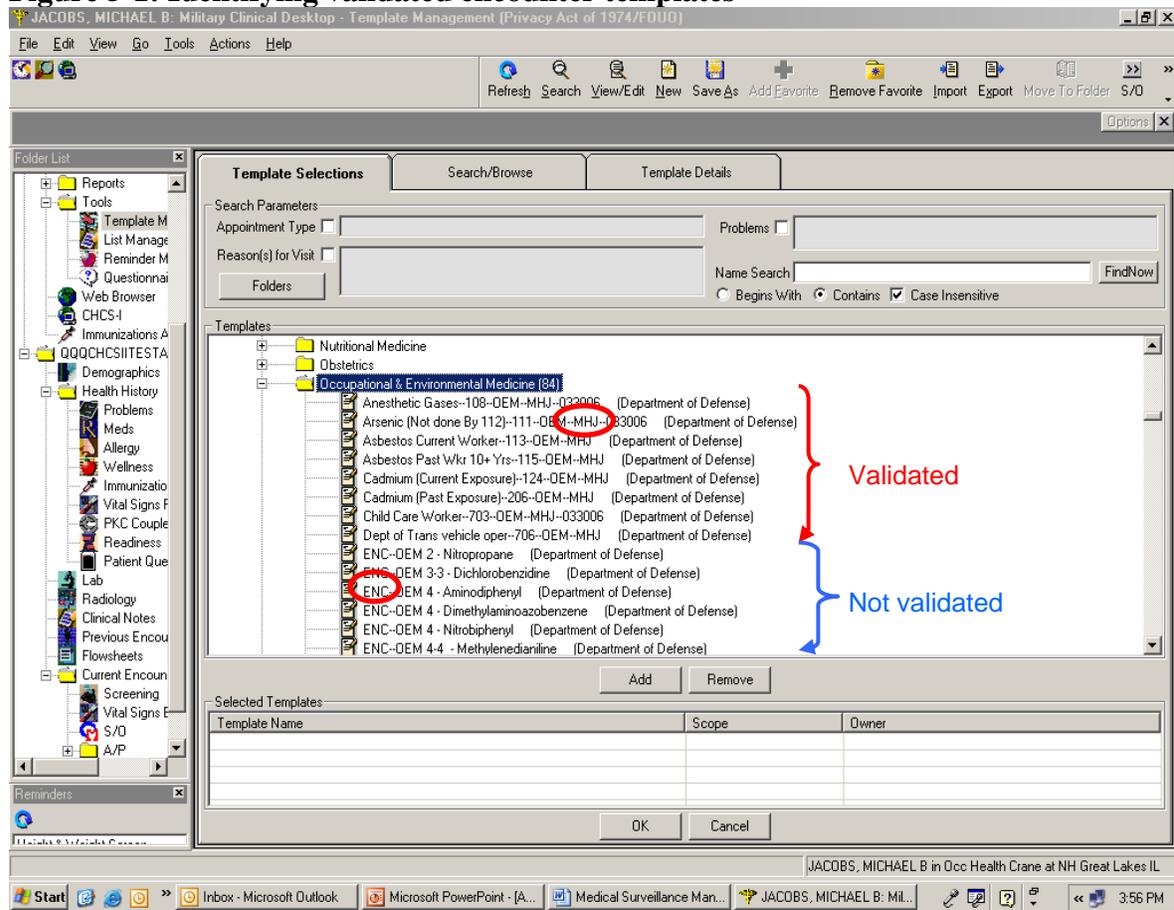
5-1. AHLTA CODING FEATURES

- 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.
- b. 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.
- c. 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
- d. 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.
- e. 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).
- f. 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 undercode 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.
- g. Support staff can document subjective and objective information for the provider in AHLTA. 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. If the provider takes ownership of the documentation, these elements are recognized by the E&M code calculator.

5-2. TEMPLATES

- a. AHLTA template capabilities include subjective and objective information templates created by individual users, AIM forms created by specialty leaders, and encounter templates that encompass all aspects of the encounter including reason for visit, subjective and objective data, procedures, orders, and coding.
- b. Navy occupational medicine has used the Medical Matrix and PC Matrix to standardize medical surveillance and certification exams. The Navy Environmental Health Center is in the process of developing and validating AHLTA encounter templates against PC Matrix 9. These validated templates are located in Enterprise/Occupational and Environmental Medicine ending with MHJ. Note that templates in this folder starting with ENC are older templates and are not validated (see Figure 5-1). Not all stressors are available at this time.

Figure 5-1: Identifying validated encounter templates



c. Currently, merging templates for workers enrolled in more than one surveillance program can only occur at the individual clinic level. Figures 5-2 through 5-12 outline this somewhat cumbersome process.

Figure 5-2: Open the Template Management function

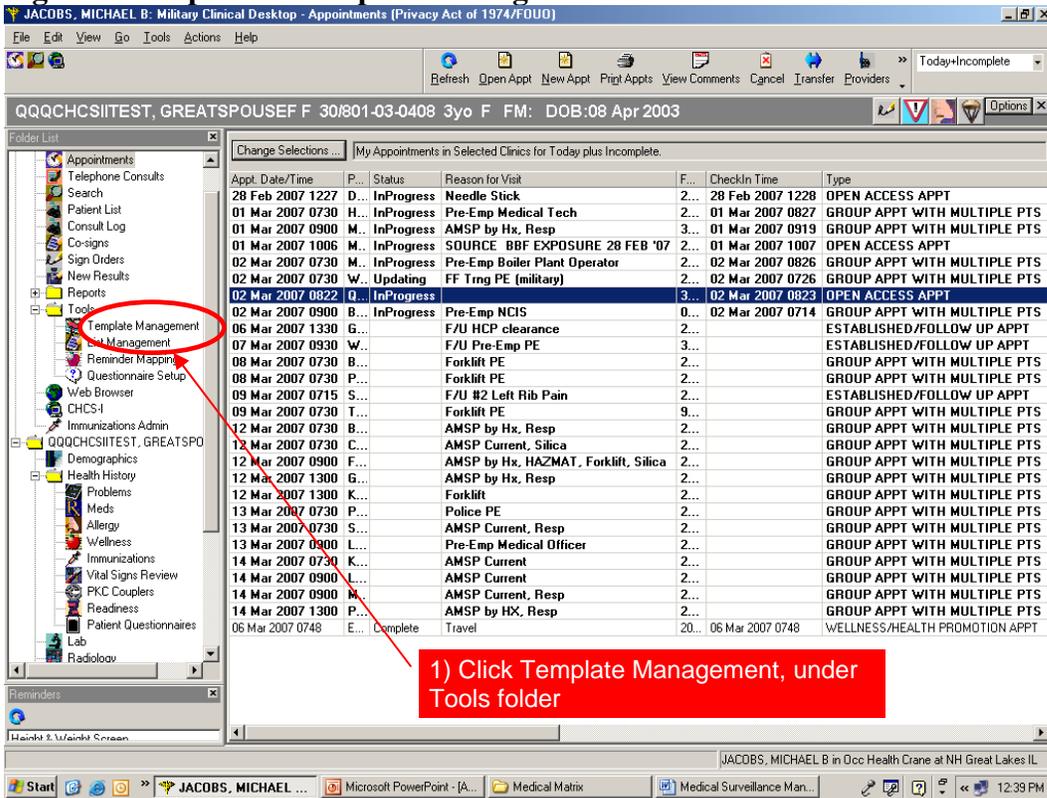


Figure 5-3: Search for the required templates

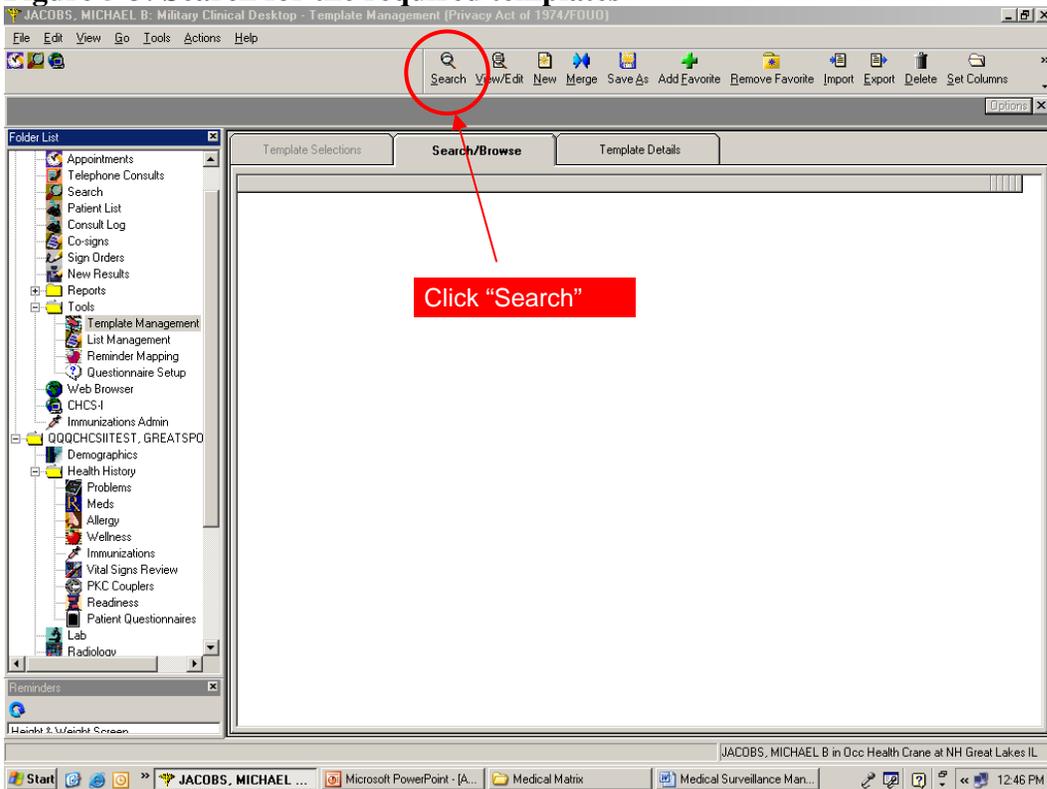


Figure 5-4: Search for enterprise level templates

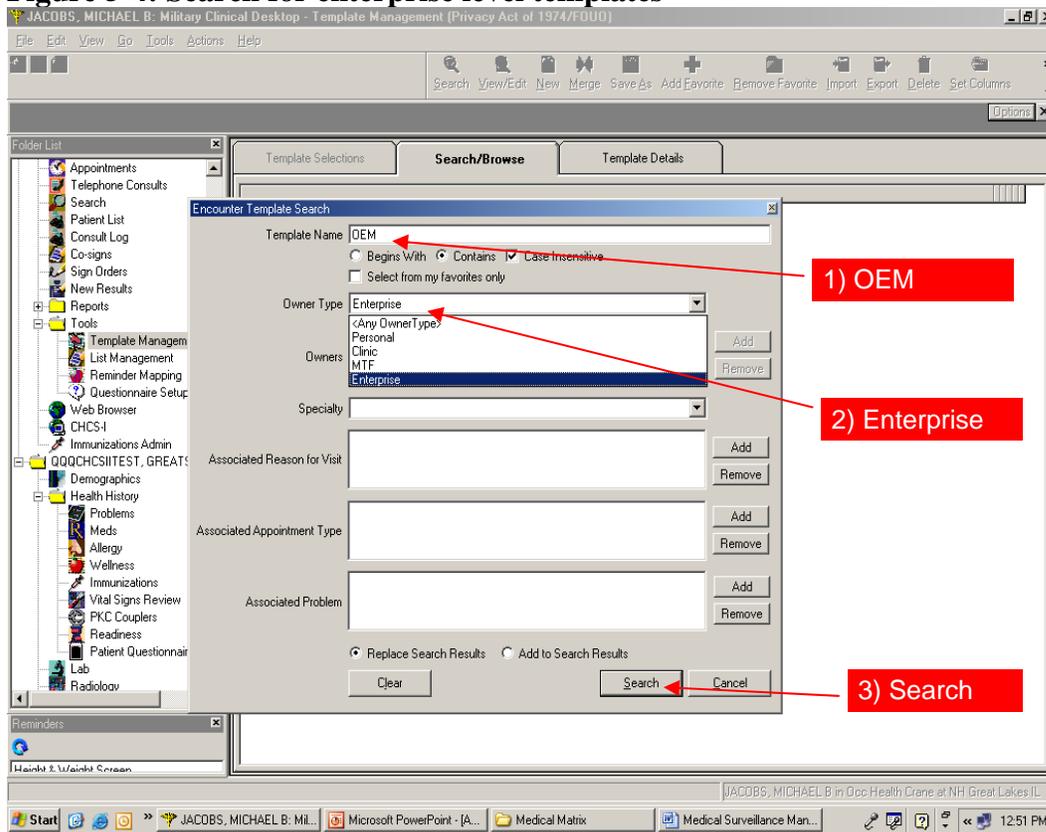


Figure 5-5: Select and merge the templates

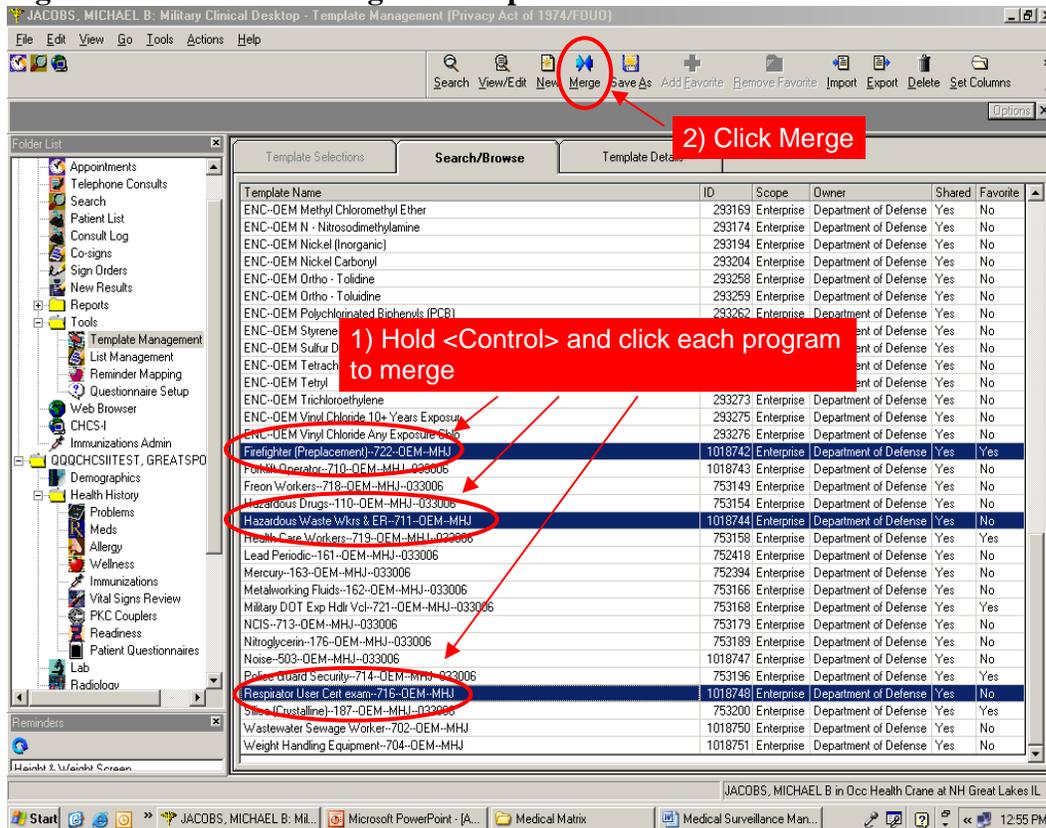


Figure 5-6: Removed merged template note then add...

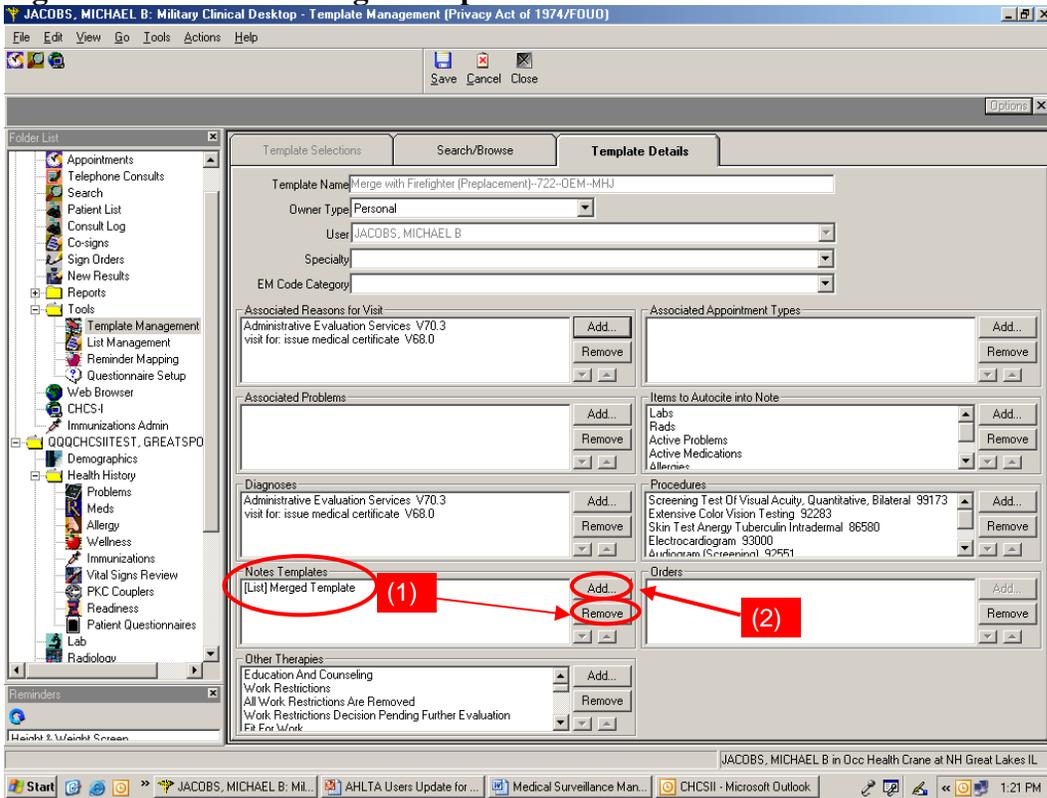


Figure 5-7: From Forms and Notes Template...

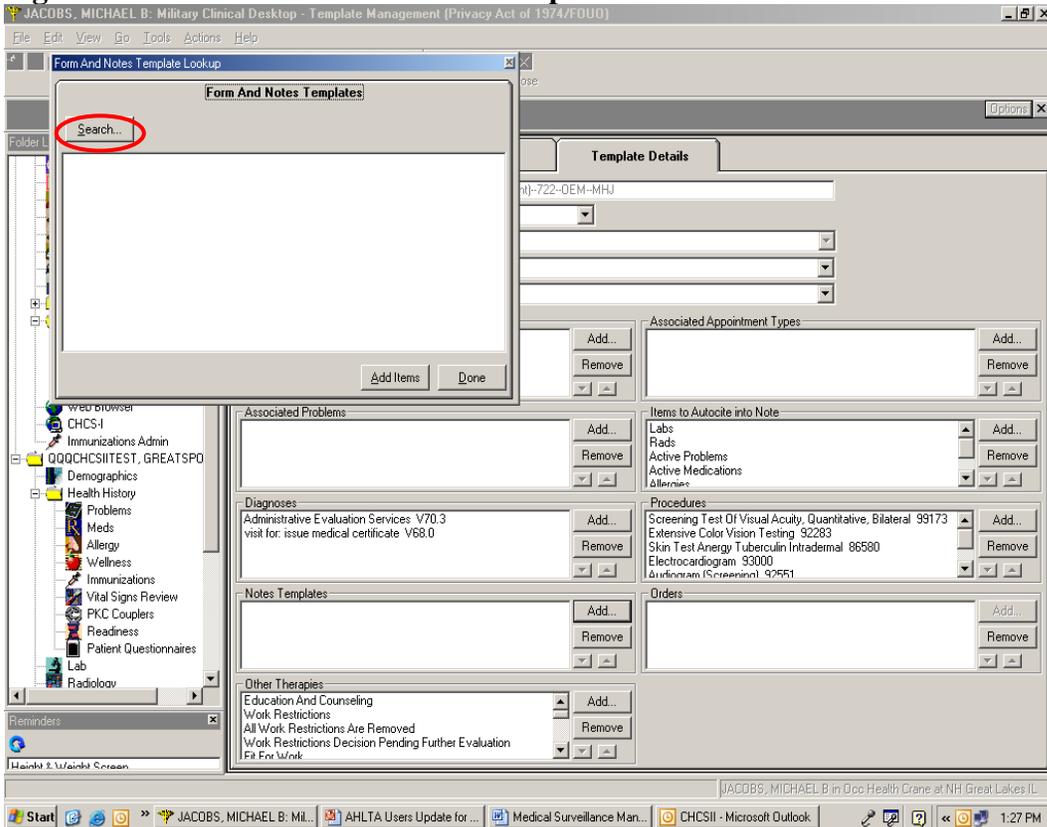


Figure 5-8: Again from OEM enterprise

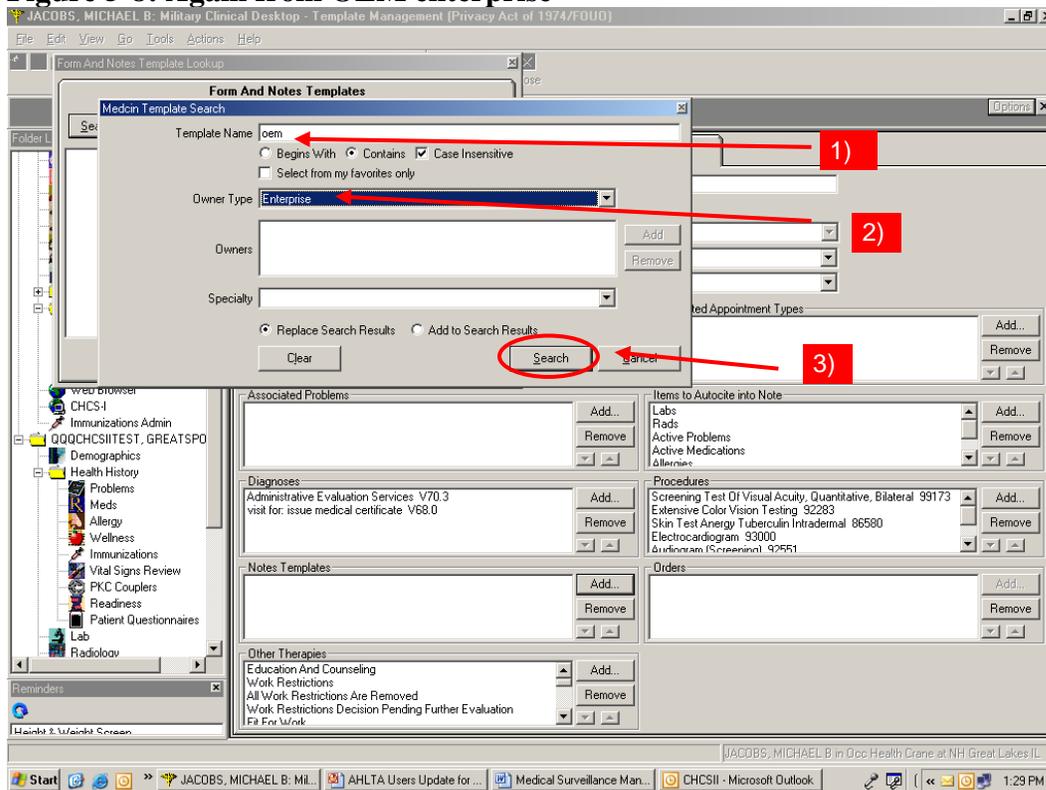


Figure 5-9: S/O Templates

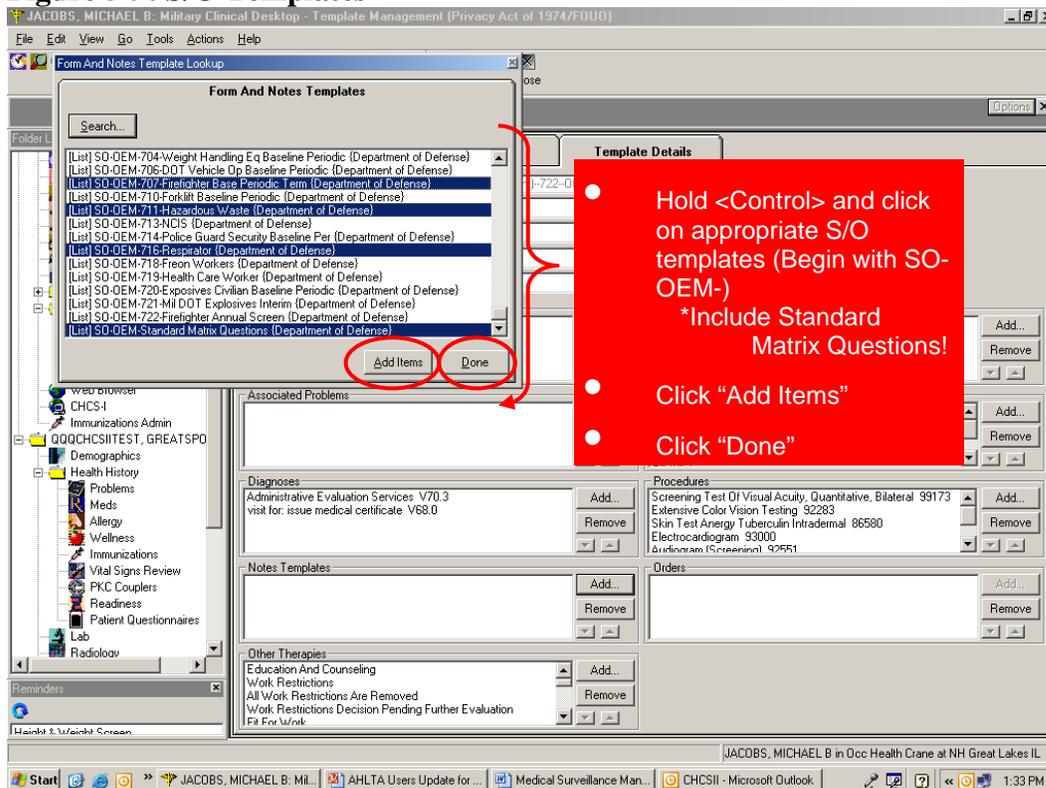


Figure 5-10: Save merged templates

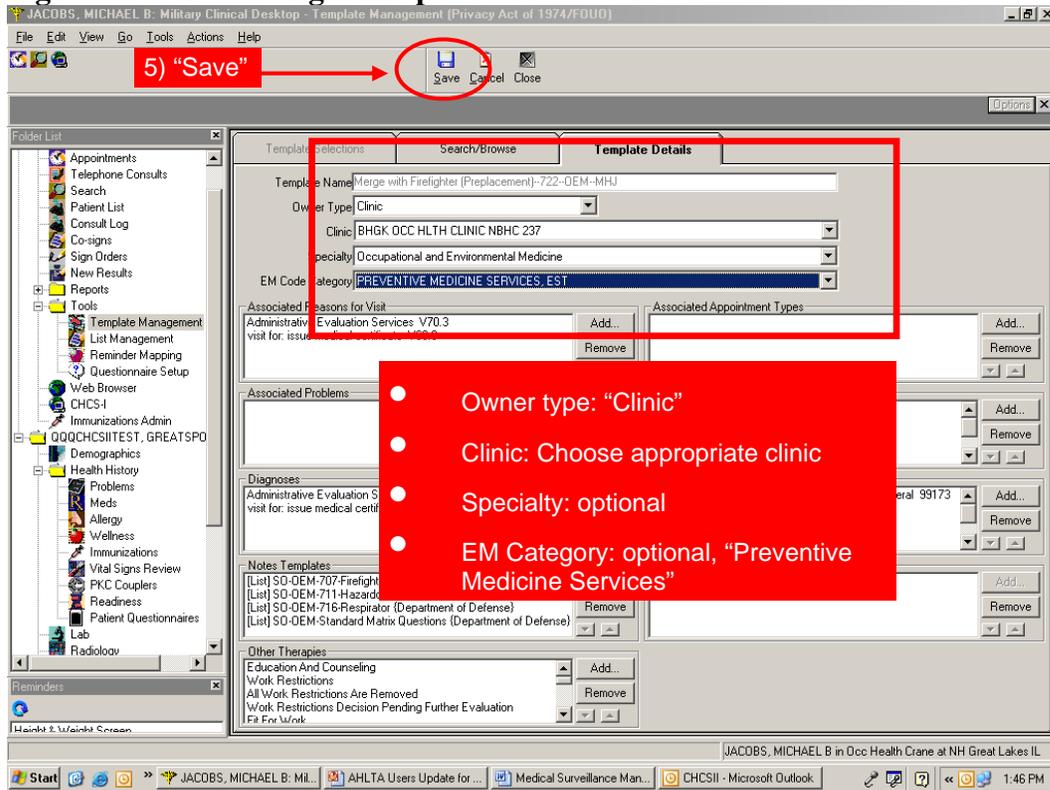


Figure 5-11: Name merged templates

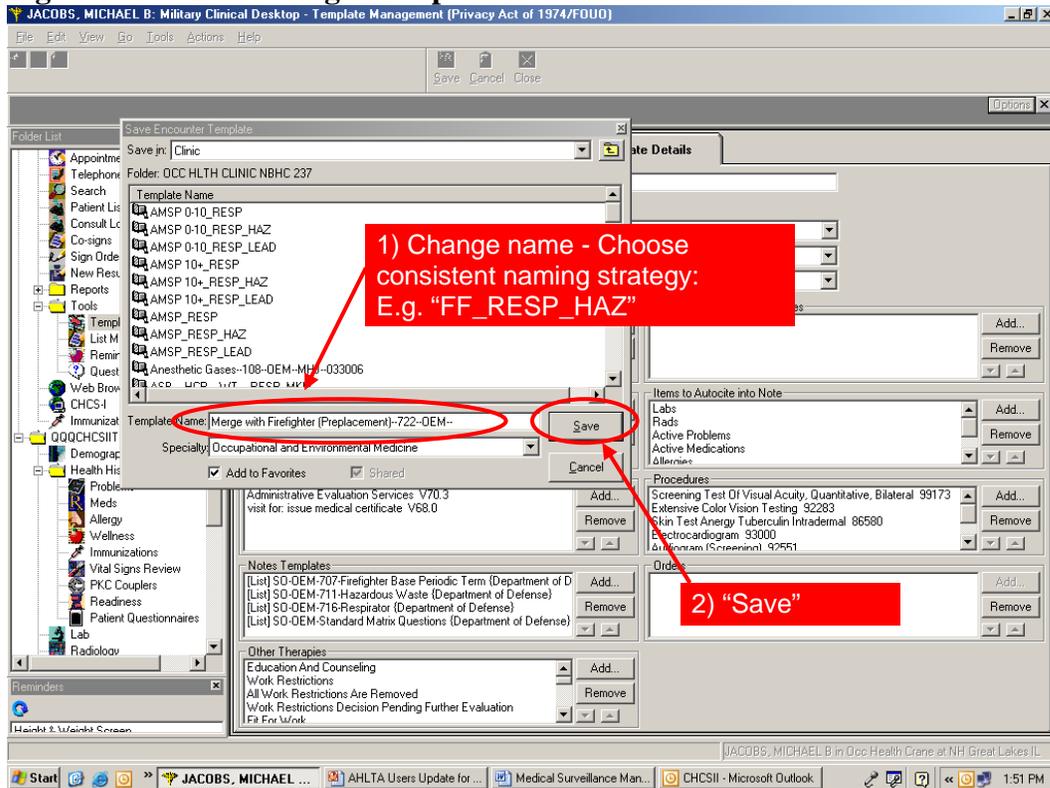
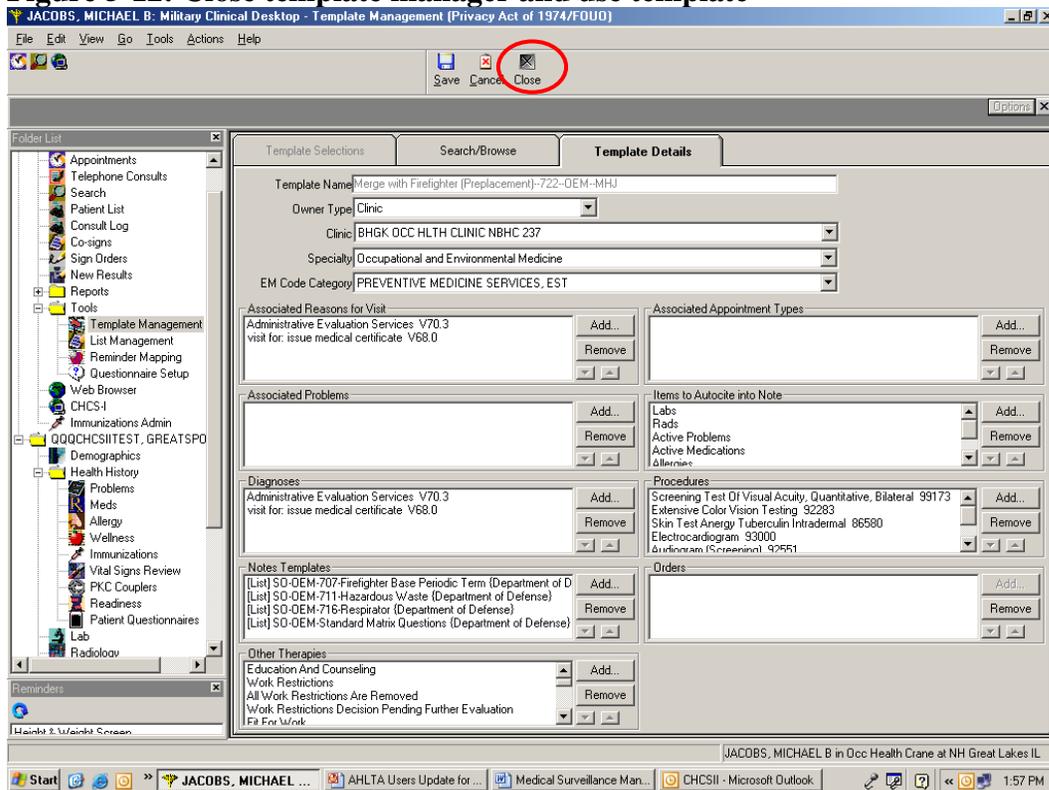


Figure 5-12: Close template manager and use template



5-3. SCREENSHOTS

a. The first step in accurate AHLTA coding occurs before the provider sees the patient. When scheduling appointments or entering telephone consults, the appointment is designated as “count” or “non-count.” Only “count” visits contribute to workload credit. Figure 5-13 and 5-14 show proper selection of a count visit to a privileged provider. Non-count visits document services provided by support staff using the 99211 or 99499 placeholder E&M codes.

Figure 5-13: Correct selection of a “count” visit when creating an appt.

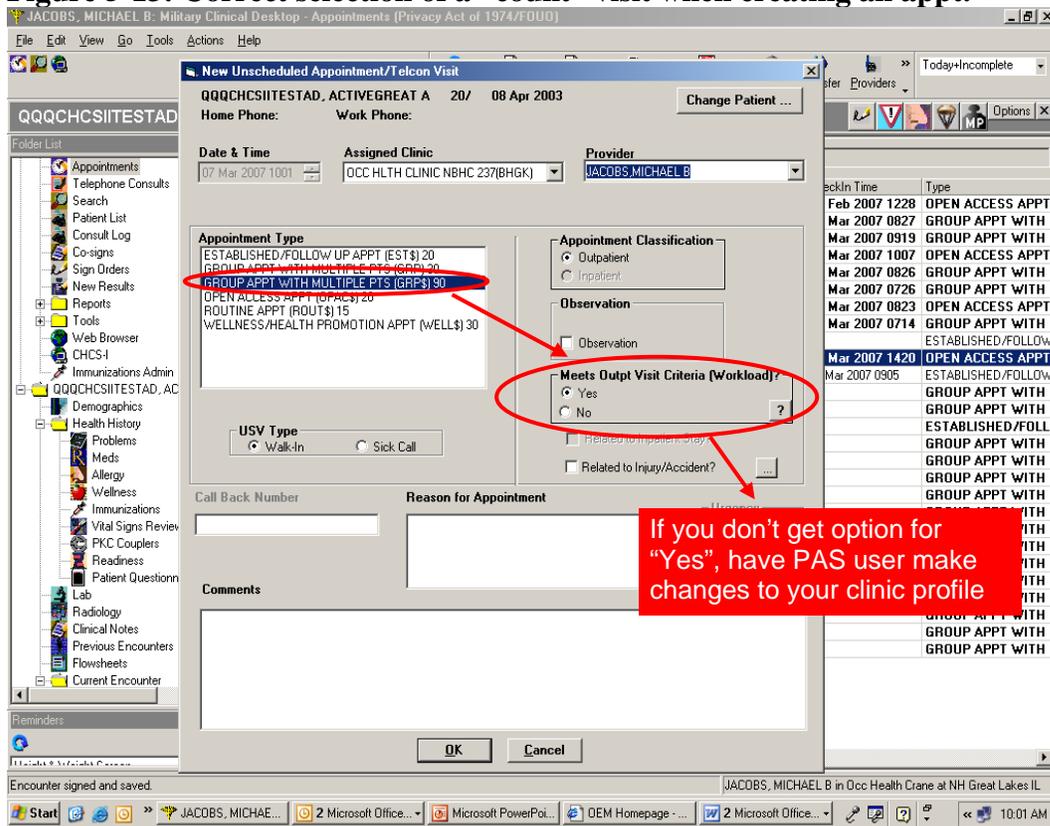
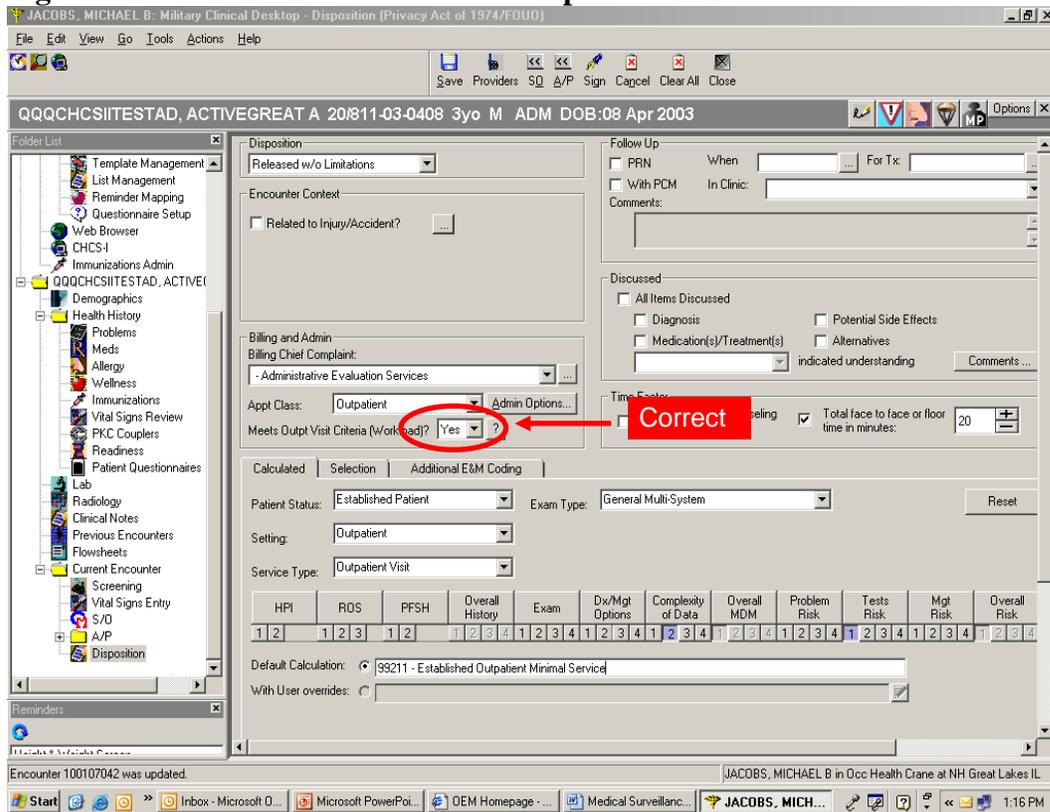


Figure 14: Selection of Count Visit in Disposition Module



b. Although the first step in coding is documentation, a full demonstration of documentation in AHLTA is beyond the scope of this document. The first screen for entry of codes is the Assessment and Plan Module. Enter ICD-9-CM codes (Figure 5-15 through 5-16), including injury and illness, V codes, and E codes, here along with CPT procedure codes and HCPCS Level II codes. This module contains the look-up features.

Figure 5-15: ICD-9-CM code entry

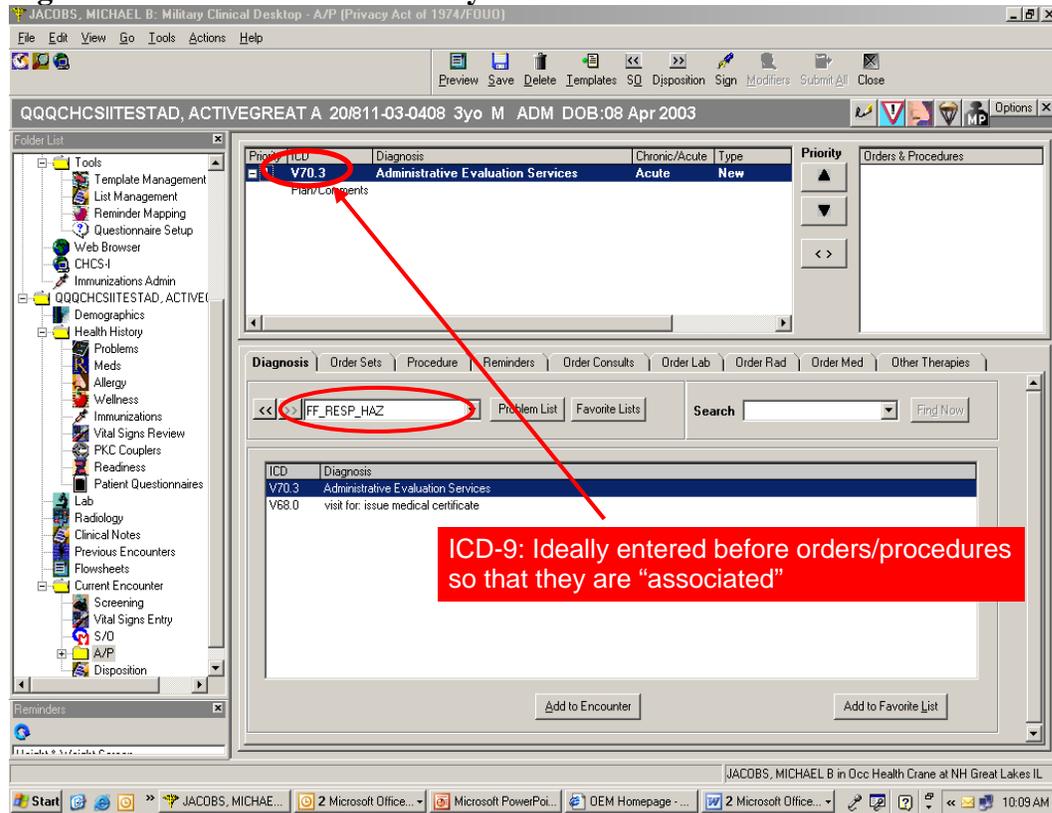
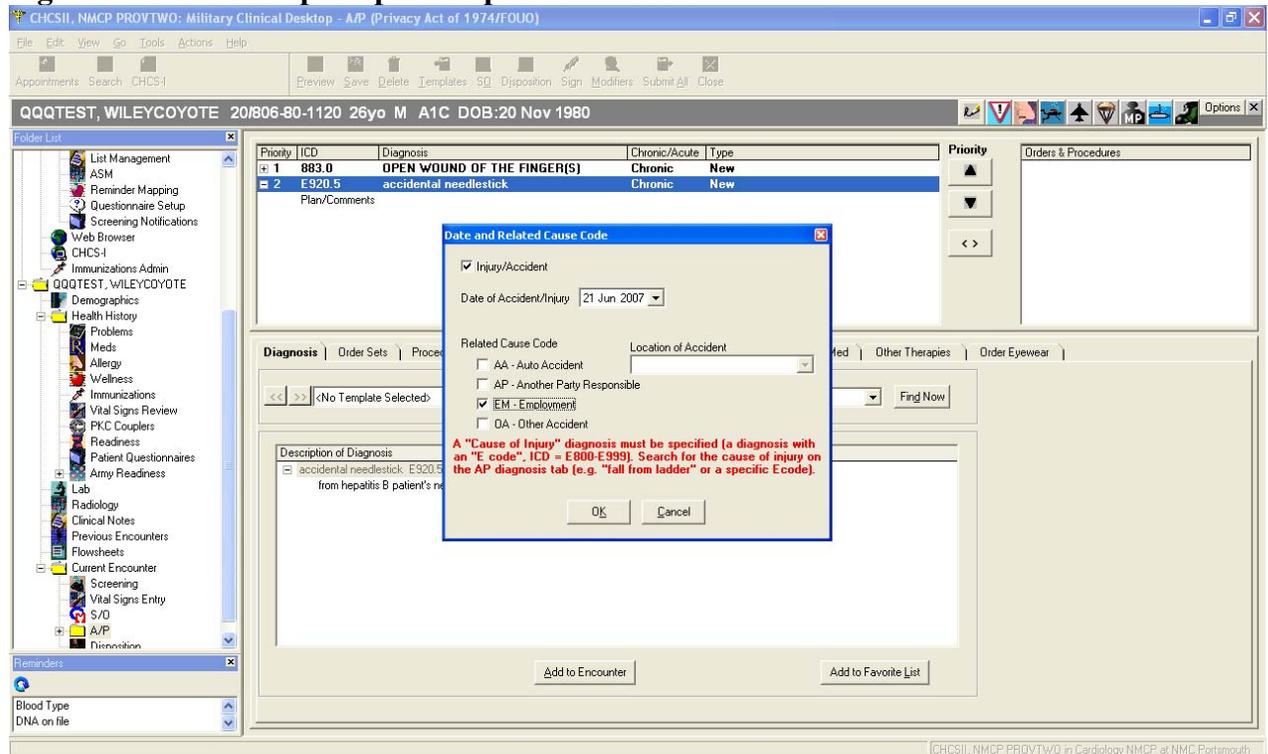


Figure 5-16: E Code prompt in disposition module



c. Enter E&M codes in the Disposition Module. This module contains the E&M coding calculator. For problem-oriented visits, remember that **the E&M code calculator only recognizes information entered via the MEDCIN tree**. Even if you used the MEDCIN tree, confirm the E&M code calculation according to the guidance provided in this manual. Clicking on each key component on the E&M calculator will provide additional detail about what elements have been included in the calculation. You can upgrade a component if you entered additional elements using free text.

Figure 5-17: Changing Service Type to Preventive Service

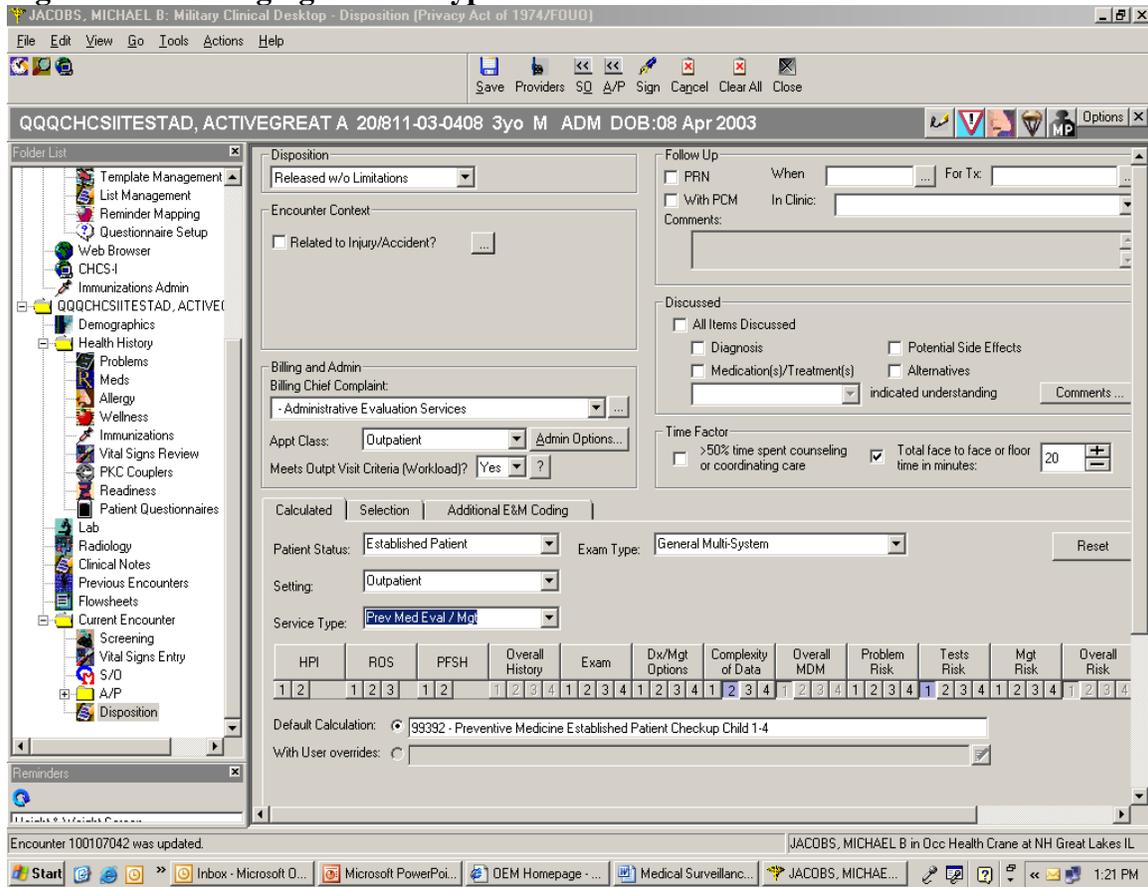
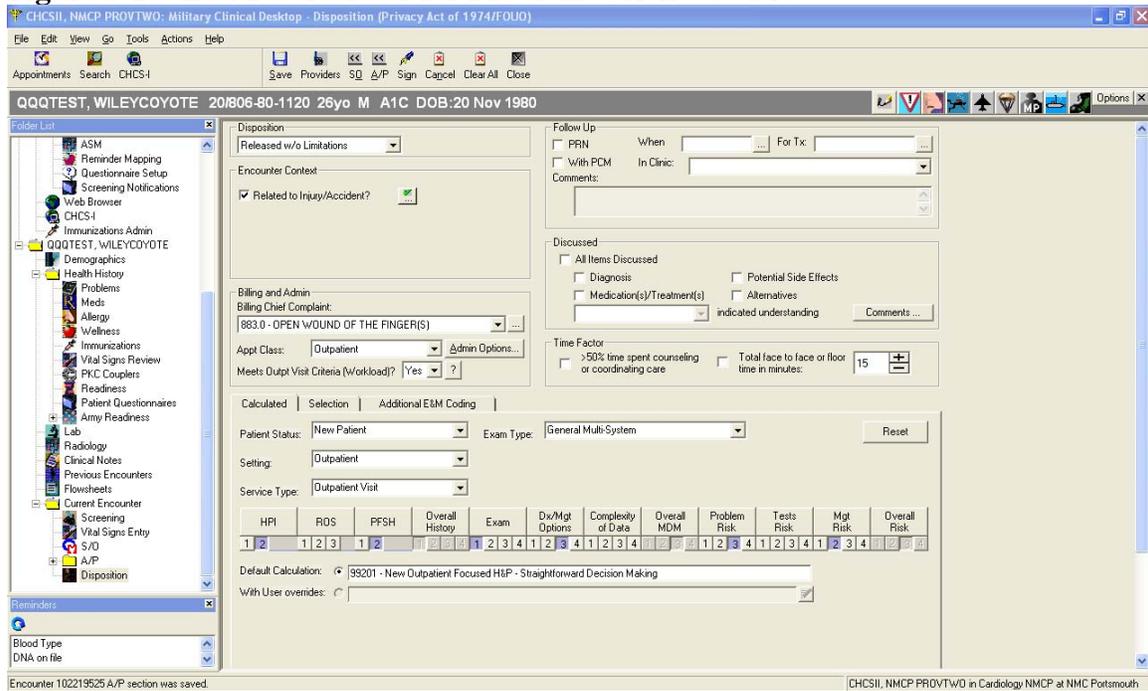
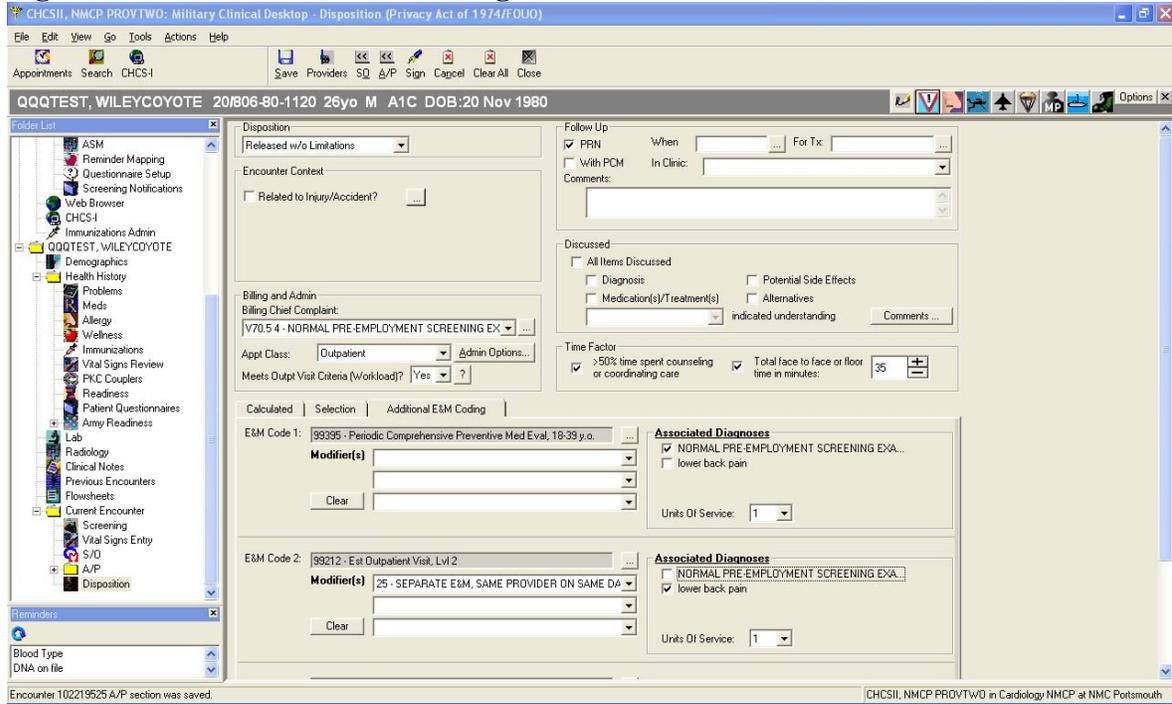


Figure 5-18: E&M Calculator for Problem-Oriented Visit



d. For combined preventive services and problem-oriented visits, remember to enter a secondary E&M code with a -25 modifier (Figure 5-19).

Figure 5-19: Additional E&M coding



CHAPTER SIX: SCENARIOS

Scenario: A 40-year-old explosives handler returns to your clinic for a biennial surveillance exam. The clinic staff draws blood and takes the specimen to the lab. They also perform an EKG, which you interpret and comment on in your note, an audiogram, and a visual acuity screening. No additional problems arise during the visit.

Coding:

ICD-9-CM:	Occupational Exam	V70.5_3
CPT:	EKG tracing and report	93000
	Venipuncture	36415
	Transport specimen	99000
	Pure tone audiogram	92552
	Visual acuity	99173
E&M:	Preventive Services, 40-64, est	99396

Scenario: A 25-year-old worker not previously known to your clinic cuts his right hand with a non-powered hand tool. You document the location and mechanism of the injury, and the time at which it occurred. You also note that 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. You describe the 3 cm laceration that requires sutures, but does not damage any tendons. You repair the laceration and order a tetanus immunization that he receives in the occupational health clinic. He also receives educational materials about signs and symptoms of infection.

Coding:

ICD-9-CM:	Open wound of hand, without complication	882.0
E Code:	Cause – Other hand tool/implement	E920.4
CPT:	Laceration repair, 2.6-5cm	12013
	Td Vaccine	90718
	Td Admin	90471
	Educational Materials	99071
E&M:	Problem-Oriented Visit, New Patient	99201-25
	History component:	Expanded problem focused
	Exam Component:	Problem focused*
	Medical decision making:	Low

*Note that the documentation of the exam limits this from being a 99202.

Scenario: A 60-year-old laboratory technician who is a military beneficiary known to your clinic presents for annual surveillance for animal-associated diseases. He is diabetic, hyperlipidemic, 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. You get an EKG in the clinic, which is normal, do a thorough cardiovascular and respiratory exam, and note that the PPD is negative. While the clinic staff draws blood to check troponin levels, you contact the patient's primary care physician and arrange further evaluation and care. You spend 45 minutes coordinating care without direct patient contact.

Coding:

ICD-9-CM:	Occupational exam	V70.5_3
	Pericardial pain	786.51
CPT:	EKG	93000
E&M:	Preventive services, 40-64, est.	99396
	Problem-oriented	99214-25
	History: Detailed	
	Exam: Detailed	
	Medical Decision Making: Moderate	
	Prolonged services	99358

Scenario: A 32-year-old family practice nurse who is a government service employee presents for an accidental needle stick during a routine blood draw in her clinic. The Occupational Health Nurse 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 affect. 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
CPT:	Needle stick HRA Counseling	96150 x 2*
E&M:	Unlisted E/M Service	99499

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

Appendix A – Problem-Oriented Provider Services: History Component

	Problem Focused*	Exp Problem Focused*	Detailed*	Comprehensive*
H P I	At least 1: <input type="checkbox"/> Location <input type="checkbox"/> Quality <input type="checkbox"/> Severity <input type="checkbox"/> Duration <input type="checkbox"/> Timing <input type="checkbox"/> Context <input type="checkbox"/> Modifying factors <input type="checkbox"/> Assoc/signs/symptoms	At least 1: <input type="checkbox"/> Location <input type="checkbox"/> Quality <input type="checkbox"/> Severity <input type="checkbox"/> Duration <input type="checkbox"/> Timing <input type="checkbox"/> Context <input type="checkbox"/> Modifying factors <input type="checkbox"/> Assoc/signs/symptoms	At least 4: or At least 3: <input type="checkbox"/> Location Chr DX <input type="checkbox"/> Quality Chr DX <input type="checkbox"/> Severity Chr DX <input type="checkbox"/> Duration <input type="checkbox"/> Timing <input type="checkbox"/> Context <input type="checkbox"/> Modifying factors <input type="checkbox"/> Assoc/signs/symptoms	At least 4: or At least 3: <input type="checkbox"/> Location <input type="checkbox"/> Quality Chr DX <input type="checkbox"/> Severity Chr DX <input type="checkbox"/> Duration Chr DX <input type="checkbox"/> Timing <input type="checkbox"/> Context <input type="checkbox"/> Modifying factors <input type="checkbox"/> Assoc/signs/symptoms
R O S	No ROS	At least 1 required: <input type="checkbox"/> Constitutional <input type="checkbox"/> Eyes <input type="checkbox"/> ENT/mouth <input type="checkbox"/> CV <input type="checkbox"/> Resp <input type="checkbox"/> GI <input type="checkbox"/> GU <input type="checkbox"/> Musc <input type="checkbox"/> Skin/Breast <input type="checkbox"/> Neuro <input type="checkbox"/> Psych <input type="checkbox"/> Endo <input type="checkbox"/> Hem/lymph <input type="checkbox"/> Allergy/Immuno	At least 2 required: <input type="checkbox"/> Constitutional <input type="checkbox"/> Eyes <input type="checkbox"/> ENT/mouth <input type="checkbox"/> CV <input type="checkbox"/> Resp <input type="checkbox"/> GI <input type="checkbox"/> GU <input type="checkbox"/> Musc <input type="checkbox"/> Skin/Breast <input type="checkbox"/> Neuro <input type="checkbox"/> Psych <input type="checkbox"/> Endo <input type="checkbox"/> Hem/lymph <input type="checkbox"/> Allergy/Immuno	At least 10 required: <input type="checkbox"/> Constitutional <input type="checkbox"/> Eyes <input type="checkbox"/> ENT/mouth <input type="checkbox"/> CV <input type="checkbox"/> Resp <input type="checkbox"/> GI <input type="checkbox"/> GU <input type="checkbox"/> Musc <input type="checkbox"/> Skin/Breast <input type="checkbox"/> Neuro <input type="checkbox"/> Psych <input type="checkbox"/> Endo <input type="checkbox"/> Hem/lymph <input type="checkbox"/> Allergy/Immuno
P F S H	No PFSH	No PFSH	At least 1: <input type="checkbox"/> Past Medical <input type="checkbox"/> Family History <input type="checkbox"/> Social History	At least 2: <input type="checkbox"/> Past Medical <input type="checkbox"/> Family History <input type="checkbox"/> Social History
*Marked column farthest left identifies complexity level of history component.				

Appendix B – Problem-Oriented Provider Services: Physical Exam Component

Organ System/Body Area	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
<p>Constitutional</p> <ul style="list-style-type: none"> <input type="checkbox"/> 3 of 7 vital signs <input type="checkbox"/> General appearance <p>Eyes</p> <ul style="list-style-type: none"> <input type="checkbox"/> Conjunctivae/lids <input type="checkbox"/> Pupils/irises <input type="checkbox"/> Optic discs/posterior segments <p>Ears/nose/throat/mouth</p> <ul style="list-style-type: none"> <input type="checkbox"/> External ears/nose <input type="checkbox"/> Otoscopic exam <input type="checkbox"/> Hearing assessment <input type="checkbox"/> Nasal mucosa/septum/turbinates <input type="checkbox"/> Lips/teeth/gums <input type="checkbox"/> Oropharynx <p>Neck</p> <ul style="list-style-type: none"> <input type="checkbox"/> External neck <input type="checkbox"/> Thyroid <p>Cardiovascular</p> <ul style="list-style-type: none"> <input type="checkbox"/> Heart palpation <input type="checkbox"/> Heart auscultation <input type="checkbox"/> Carotid arteries <input type="checkbox"/> Abdominal aorta <input type="checkbox"/> Femoral arteries <input type="checkbox"/> Pedal pulses <input type="checkbox"/> Extremity edema/varicosities <p>Respiratory</p> <ul style="list-style-type: none"> <input type="checkbox"/> Respiratory effort <input type="checkbox"/> Chest percussion <input type="checkbox"/> Chest palpation <input type="checkbox"/> Auscultation <p>Breasts</p> <ul style="list-style-type: none"> <input type="checkbox"/> Inspection <input type="checkbox"/> Palpation <p>Gastrointestinal/Abdomen</p> <ul style="list-style-type: none"> <input type="checkbox"/> Palpation including masses/tenderness <input type="checkbox"/> Liver/spleen <input type="checkbox"/> Hernia <input type="checkbox"/> Anus/perineum/rectum when indicated <input type="checkbox"/> Fecal occult blood when indicated <p>Genitourinary – Male</p> <ul style="list-style-type: none"> <input type="checkbox"/> Scrotal contents <input type="checkbox"/> Penis <input type="checkbox"/> Prostate <p>Genitourinary – Female</p> <ul style="list-style-type: none"> <input type="checkbox"/> External genitalia/vagina <input type="checkbox"/> Urethra <input type="checkbox"/> Bladder <input type="checkbox"/> Cervix <input type="checkbox"/> Uterus <input type="checkbox"/> Adnexa <p>Musculoskeletal</p> <ul style="list-style-type: none"> <input type="checkbox"/> Gait and station <input type="checkbox"/> Digits/nails <input type="checkbox"/> Extremities/joints <p>Skin</p> <ul style="list-style-type: none"> <input type="checkbox"/> Inspection <input type="checkbox"/> Palpation <p>Neurologic</p> <ul style="list-style-type: none"> <input type="checkbox"/> Cranial nerves <input type="checkbox"/> Deep tendon reflexes <input type="checkbox"/> Sensation <p>Psychiatric</p> <ul style="list-style-type: none"> <input type="checkbox"/> Judgment/insight <input type="checkbox"/> Orientation <input type="checkbox"/> Memory <input type="checkbox"/> Mood/affect <p>Hematologic/lymphatic/immunologic</p> <ul style="list-style-type: none"> <input type="checkbox"/> Neck nodes <input type="checkbox"/> Axillary nodes <input type="checkbox"/> Groin nodes <input type="checkbox"/> Other nodes 	<p>1-5 elements from any area or system</p>	<p>At least 6 elements from any area or system</p>	<p>At least 2 elements from each of 6 areas/systems</p> <p>OR</p> <p>At least 12 elements in 2 or more areas/systems</p>	<p>Perform all elements in at least 9 areas/systems</p> <p>AND</p> <p>Document at least 2 elements in each of the areas/systems</p>

Appendix C – Problem-Oriented Provider Services: Medical Decision-Making Table of Risk

Type of decision making	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	<ul style="list-style-type: none"> One self-limited/minor problem (e.g., contusion, insect bite, etc.) 		<ul style="list-style-type: none"> Rest, gargles Elastic bandages, superficial dressings
Low	<ul style="list-style-type: none"> One or two self-limited problems One stable chronic illness Acute, uncomplicated illness or injury Low risk of complications, morbidity or mortality 	<ul style="list-style-type: none"> Non-invasive/minimally invasive lab tests (e.g., urinalysis, venipuncture, etc) Non-invasive diagnostic procedures (e.g., EEG, ECG, ultrasound, etc) Physiologic tests not under stress Non-cardiovascular imaging studies without IV or intrathecal contrast (e.g., upper GI, barium enema, etc) Skin biopsy Superficial needle biopsy Arterial puncture 	<ul style="list-style-type: none"> Rest, exercise, diet, stress management Medication management with minimal risk Referrals without detailed discussion or care plan
Moderate	<ul style="list-style-type: none"> Three or more self-limited problems One or more chronic mild problems with ongoing activity (active problem) Two or three stable chronic illnesses or problems requiring evaluation New illness, injury or problem with uncertain prognosis Acute illness with systemic symptoms Moderate risk of complications, morbidity or mortality (i.e., uncertain prognosis, possibility of prolonged functional impairment) 	<ul style="list-style-type: none"> Data to be obtained/reviewed requiring at least 10 minutes of physician time Physiological tests under stress Endoscopy for average risk patient (e.g., stable vitals, non-critical illness) Deep needle/incisional biopsy Interventional cardiovascular or radiologic procedure for average risk patient Percutaneous removal of body cavity fluid IV contrast imaging Therapeutic or diagnostic spinal/nerve injections 	<ul style="list-style-type: none"> Referrals with detailed discussion/care plan Medication management with moderate risk (e.g., digoxin, warfarin) Discussion for psychotherapy and/or counseling Arranging hospitalization for non-critical illness/injury Referral for comprehensive pain management rehabilitation
High	<ul style="list-style-type: none"> One or more acute or chronic severe problems with ongoing activity Four or more stable chronic problems 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 (i.e., possibility of significant prolonged functional impairment) 	<ul style="list-style-type: none"> Data to be obtained/reviewed requiring at least 20 minutes of physician time Intra-arterial cerebral angiography (excludes MRA) 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) 	<ul style="list-style-type: none"> Emergency hospitalization Medications requiring intensive monitoring (e.g., initiation of IV heparin, IV antiarrhythmics; antineoplastics) Surgery or procedure with ASA 2* or higher risk status Decision not to resuscitate or to de-escalate care because of poor prognosis Mechanical ventilator management

Appendix D – Problem-Oriented Provider Services: Final E&M Selection

	New Patient/Consult Requires all 3 components - choose lowest column					Established Patient Requires at least 2 components or choose lowest column				
History	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive	Comprehensive	Minimal	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
Exam	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive	Comprehensive	Physician may not be present	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
Medical Decision-making	Minimal	Minimal	Low	Medium	High		Minimal	Low	Medium	High
E&M Code	99201/ 99241	99202/ 99242	99203/ 99243	99204/ 99244	99205/ 99245	99211	99212	99213	99214	99215

OH Exam Type	Description	Diagnosis (ICD-9) Code(s)	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			
Certification	Respirator, Food Service, Childcare Worker (Matrix 700 series except exams directly below)	Primary V68.09 Secondary Diagnosis codes for pertinent medical problems	New Pt 99385 (18-39) 99386 (40-64) 99387 (65+)		G0102 Prostate Screening 93000 EKG w/interp 93005 EKG w/o interp G0375 Smok. Cess. (3-10) G0376 Smok. Cess. (11+)
Vehicle Exam	Commercial Driver, Explosive Handler/Vehicle Operator, Forklift, Weight Handling Equipment Operator	Primary V70.5_3 Secondary Diagnosis codes for pertinent medical problems	Established Pt 99395 (18-39) 99396 (40-64) 99397 (65+)		94010 Spirometry 99173 Snellen Chart 36415 Venipuncture 99000 Specimen Handling
Fitness for Duty	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 99456		
Reproductive Toxicity Evaluation	Assessing/communicating reproductive risks in a job	Primary V70.5_7 Secondary V22.2	New Pt 99385 (18-39) 99386 (40-64) 99387 (65+)		N/A
Hearing Loss Medical Evaluation	Evaluation for work-relatedness and/or impairment	Primary V70.5_7 Secondary Diagnosis codes for pertinent medical problems.	Established Pt 99395 (18-39) 99396 (40-64) 99397 (65+)	Extensive Record Review 99358 for first hour + 99359 each additional ½ hr	
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 Diagnosis codes for pertinent medical problems.			G0102 Prostate Screening 93000 EKG w/interp 93005 EKG w/o interp G0375 Smok. Cess. (3-10) G0376 Smok. Cess. (11+) 94010 Spirometry 99173 Snellen Chart 36415 Venipuncture 99000 Specimen Handling
Military Separation or Retirement Exam	Self-Explanatory	Primary V70.5_9 Secondary Diagnosis codes for pertinent medical problems			
MSC Physical Exams	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			
Deployment Screenings	Military pre- and post-deployment health assessments	Primary V70.5_4 – Pre-deployment V70.5_6 - Post-deployment Secondary Diagnosis codes for pertinent medical problems			

Special Case-Combined Problem and Preventive Visit	Patient appt for preventive exam, medical problem(s) requiring additional eval & management addressed	Primary V70.5_X Secondary Diagnosis codes for pertinent medical problems		New Pt 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 Pt 99212_25 (PF 10 min) 99213_25 (EPF 15 min) 99214_25 (D 25 min) 99215_25 (C 40 min)
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 Pt 99201 (PF 10 min) 99202 (EPF 20 min) 99203 (D 30 min) 99204 (C 45 min) 99205 (C 60 min)	*See Superbill
Asbestos CXR F/U	Visit for follow-up of abnormal asbestos surveillance CXR	Confirmed Asbestosis 501 Non-specific CXR finding 793.1	Established Pt 99212 (PF 10 min) 99213 (EPF 15 min) 99214 (D 25 min) 99215 (C 40 min)	Extensive Face to Face 99354 for first hour + 99355 each additional ½ hr N/A
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 medical problems	New Pt 99385 (18-39) 99386 (40-64) 99387 (65+) Established Pt 99395 (age 18-39) 99396 (40-64) 99397 (65+)	G0102 Prostate Screening 93000 EKG w/interp 93005 EKG w/o interp G0375 Smok. Cess. (3-10) G0376 Smok. Cess. (11+) 94010 Spirometry 99173 Snellen Chart 36415 Venipuncture 99000 Specimen Handling

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