The Encounter Classification Handbook for Military Occupational and Environmental Medicine

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The Encounter Classification Handbook for

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This 5th Edition of the Encounter Classification Handbook (formerly titled The Coding Manual and known as the "Orange Book") is an update to the 4th Edition focused on bringing the Handbook into conformity with ICD-10; ICD-10 represents a major change from ICD-9, and no ICD-9 code remains the same in ICD-10. Some items identified in this Manual are left blank or marked as uncertain, pending clarification to be published in a future edition. The primary editors of the update are Diana Stuart, CPC, CPC-H, CPMA, CEMC, CCS-P, CRS, and Lisa Rosenthal, CCS-P, with input from CAPT Alan Philippi, MC, CDR James Pate, MC, Loraine O'Berry, RN, and John Muller, MD, MPH.

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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 Current Procedural Terminology (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.

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. Clearly state why the patient is presenting (i.e., well visit, medical certificate, or condition for problem oriented visit). See paragraph 2.1.

1.1.b. A new patient is one who is new to the practice and has not been seen within the last three years. See paragraph 2.5.

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

1.1.c.1. 99211 (Nurse/Tech) Evaluation and Management (E&M) level. See paragraph 3.1.a.

1.1.c.2. Procedure(s) and/or service(s) performed:

- Use CPT code for procedure and/or service and 99499 when the patient presents for the procedure only.
- Document all details regarding the service(s) provided. See paragraph 3.1.g.

1.1.d. Patient check-in and check-out encounters with non-privileged providers are coded as an administrative visit with CPT code 99499. See paragraph 3.1.

1.1.e. 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 Armed Forces Health Longitudinal Technology Application (AHLTA) disposition screen. Non-privileged providers may not use this option. See paragraph 2.5.

1.1.f. Use an external cause code (Y-code) only when a patient presents for initial injury care to the military treatment facility (MTF). Document how, when and where the injury occurred. Y-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.g. Use an International Classification of Disease, 10th Revision- Clinical Modification (ICD-10-CM) code for the condition that prompted the workers' visit. See paragraph 2.1.a.

1.1.h. Use an ICD-10-CM injury code in lieu of an ICD-10-CM symptom code when applicable. See paragraph 2.1.

1.1.i. Include details for any test(s) and/or procedures performed during the encounter. See paragraph See Section 3.1.d.

1.1.j. 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 3.1.d.

1.1.k. Exposure visits should be coded as problem focused visits (usually 99213 with supporting documentation). See paragraph 2.5.

1.1.l. 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 2.6.

1.1.m. 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 2.6.b .

1.1.n. 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 to the second E&M service. See paragraph 2.6.c.

1.1.o. 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 2.6.a.

1.1.o.1. 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 2.6.b.

1.1.p. 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 2.6.

1.1.q. 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 2.9.

1.1.r. Electrocardiograms (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 2.11.b.

1.1.s. 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 3.1.a.

1.1.t. Use code Z02.79 when issuing a medical certificate. See paragraph 2.3.c.2.

1.1.u. Use code Z33.1 (incidental pregnancy) as a secondary code when applicable. The date of conception and estimated delivery date must be documented in the note. See Table 2.7.

1.1.v. For dates of services on or after 1 October 2015, Unique Codes (*DoD0211 - DoD0229*) will be used in conjunction with ICD-10-CM codes. See paragraph 2.3.c.1.

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/ Unique Codes for Health Examination V70.5 (Z02.7x..)?

Extender	*Unique	Purpose	Description
Z02.3	***N/A***	Armed Forces Medical Exam	Pre-enlistment General Exam
Z02.89 ?? Limited category of codes for PEs	***[DoD0217]*** ***[DoD0218]***	Aviation Exam	Initial qualifying and any recurring aviation exam
V70.5_2??	***[DoD0225]***	Periodic Health Assessments	Includes PHA (DD2766)
V70.5_3??	***[DoD0214]*** ***[DoD0215]*** ***[DoD0216]*** ***[D0D0224]***	**Occupational Exam**	**Includes initial certifying and recurring exams**
V70.5_4??	***N/A***	Pre-Deployment Related Encounter	Related to a projected deployment. Not pre-deployment assessment
V70.5_5??	***N/A***	Intra-Deployment Related Encounter	Includes family members experiencing deployment related condition
V70.5_6??	***N/A***	Post-Deployment Related Encounter	Includes family members experiencing deployment related condition
V70.5_7??	***[DoD0219]*** ***[DoD0220]*** ***[DoD0221]*** ***[DoD0227]*** ***[DoD0228]***	**Duty Status Determination/Suitability Exam**	**Includes return to work and disability evaluation**
V70.5_8??	***[DoD0229]***	Special Program Accession Encounter	Prior service entry to officer programs
V70.5_9??	***[DoD0222]***	Separation/Retirement Exam	

Extender	*Unique	Purpose	Description
V70.5_A Z02.89	***N/A***	Health Exam of Defined Subpopulations	School Physicals, etc.
V70.5_B ??	***[DoD0222] [DoD0223]***	Abbreviated Sep/Retirement Exam	Partial exam updating complete exam within a defined period
V70.5_C ??	***[DoD0226]***	PRT Screening	Identified conditions are secondary codes
V70.5_D ??	***[DoD0211]***	Pre-Deployment Assessment	Identified conditions are secondary codes
V70.5_E ??	***[DoD0212]***	Initial Post-Deployment Assessment	Identified conditions are secondary codes
V70.5_F ??	***[DoD0213]***	Post-Deployment Health	Identified conditions are secondary codes
V70.5_H ??	***N/A***	Other Exam Defined Population	Identified conditions are secondary codes
Z02.79		Issuance of Medical Certificate	Use only as primary code, do not use in conjunction with V70.x

*DoD Unique Codes are used in conjunction with ICD-10-CM codes on 1 October 2015. See section 2.3.c.1.

Coding Concepts

1.3. Capturing Patient Services

1.3.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.

1.3.b. The military has 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.

1.4. Coding Systems

1.4.a. The ICD-10-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-10-CM manual is updated annually on October 1st. A three-digit code represents the general diagnosis, with up to four additional charactersafter the decimal adding additional detail. The first character is a letter (alphabetical) using all letters except U. The third through the seventh characters can be alpha or numeric. The first step in identifying the services provided is establishing the medical necessity of the patient visit through ICD-10-CM diagnostic coding.

1.4.b. The Healthcare Common Procedure Coding System (HCPCS) Level I, commonly known as CPT, is the coding system describing the type of PROCEDURES and SERVICES that were provided to the patient. After ICD-10-CM diagnostic codes establish the medical necessity of the visit, CPT codes determine the amount of reimbursement for services. 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. A subset of CPT codes, E&M codes, describe COMPLEXITY of care provided, PLACE of service, and TYPE of service. Higher intensity of care results in higher reimbursement.

1.4.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 expenses so that the clinic can be budgeted adequately each year to meet their patient demands.

1.4.d. On October 1, 2015,the current DoD ICD-9-CM coding system (with 13,600 codes) will be replaced with ICD-10-CM (with more than 8,000 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).

1.5. Reimbursement and Workload Credit

1.5.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.

1.5.b. The mechanism by which a military clinic submits its “claim” for reimbursement for outpatient services is provider entry of ICD-10-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.

1.5.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.

1.5.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

2. ICD-10-CM Diagnostic Coding

2.1. Injury and Illness Coding

2.1.a. ICD-10-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-10-CM code, which establishes the medical necessity of the visit. Table Table 2.1 lists some ICD-10-CM codes commonly used in OEM clinics.

2.1.b. Use only the ICD-10-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 right foot laceration will be coded only as S91.311A (under category Laceration) 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 Type II Diabetes Mellitus with Peripheral Angiopathy (E11.51) coded in addition to the foot laceration (S91.311A) and external cause code for the first presentation to the MTF. ICD-10-CM diabetes codes are combinations codes that include the type of diabetes mellitus, the affected body system, and the complications affecting that body system. Include ICD-10-CM code Z79.4 for long term (current) use of insulin. 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.

2.1.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-10-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.

2.1.d. Although AHLTA provides a rudimentary look-up of ICD-10-CM codes, it does not include all of the coding rules and information contained in the ICD-10-CM manual. AHLTA should not be relied on for coding.

2.1.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 alphanumeric range. Enter the tabular index (Volume 1) using this number. Select the highest order number, up to seven characters, 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-character code and any pertinent coding guidelines (i.e., multiple coding required, etc.). Do not use a symptom code when a definitive diagnosis is established.

2.1.f. If an employee has signs and symptoms but no diagnosis yet, refer to Section 18 of the ICD-10-CM book titled, "Symptoms, Signs, and Abnormal Clinical/Laboratory Findings, NEC." 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.

Table 2.1 ICD-10-CM Codes Commonly Used

Illnesses, Signs & Symptoms	
R10.12	RUQ Abdominal Pain
R10.13	LUQ Abdominal Pain
R10.31	RLQ Abdominal Pain
R10.32	LLQ Abdominal Pain
R10.81	Abdominal Tenderness
R10.84	Generalized Abdominal Pain
R94.31	Abnormal EKG
R91.8	Abnormal Chest X-Ray
R82.90	Abnormal Urine Order
R91.8	Abnormal Chest X-Ray
F10.10	Alcohol Abuse
R41.82	Altered Mental Status
D64.9	Anemia
M25.579	Ankle Pain
F41.9	Anxiety State, Unspecified
M54.9	Back pain
M54.5	Low Back Pain
R07.9	Chest Pain
J00	Common Cold
R56.9	Convulsions
R05	Cough
Z71.89	Counseling, Injury Prevention
Z71.3	Counseling, Nutritional
E86.0	Dehydration
E10.9	Diabetes Type I, Controlled
E11.9	Diabetes Type II, Controlled
Z79.4	Diabetes – Long Term Insulin
R19.7	Diarrhea
R42	Dizziness/Vertigo
F19.10	Drug Abuse
R13.10	Dysphagia
R06.00	Dyspnea
R60.9	Edema
R03.0	Elevated BP Reading
M25.529	Elbow (Upper Arm Joint) Pain
J43.9	Emphysema
R04.0	Epistaxis
R29.810	Facial Weakness
R53.83	Fatigue
R50.9	Fever
M79.646	Finger Pain
R26.9	Gait
K21.9	GERD
M79.643	Hand Pain
J30.1	Hay Fever
R51	Headache
G43.909	Headache, Migraine
G44.20	Headache, Tension
M25.559	Hip Pain
E78.0	Hypercholesterolemia
R73.9	Hyperglycemia
I10	Hypertension
E916.2	Hypoglycemia
M25.569	Knee Pain
R53.xx	Malaise/Fatigue/Weakness
R11.0	Nausea Alone
R11.2	Nausea and Vomiting
R20.x	Numbness
E66.9	Obesity
R06.01	Orthopnea
M15.9	Osteoarthrosis
R52	Pain, Generalized
M79.609	Pain in Limb
R00.2	Palpitations
F41.0	Panic Disorder
J02.9	Pharyngitis, Acute
J18.9	Pneumonia
Z33.1	Pregnant State, Incidental
J98.4	Pulmonary Nodule
R56.9	Seizure Disorder
R06.02	Shortness of Breath
M25.519	Shoulder Joint Pain
R47.81	Slurred Speech
M79.89	Swelling in Limbs
R55	Syncope
R00.0	Tachycardia
F17.210	Tobacco Dependence
Z72.0	Tobacco Use
J06.9	URI
N39.0	Urinary Tract Infection
R40.4	Transient Alteration of Awareness
R11.10	Vomiting
R06.2	Wheezing
M25.539	Wrist Pain

Injuries & Accidents	
S60.41xA	Finger Abrasion**
S90.00XA	Ankle, Contusion
S05.70XA	Avulsion of Eye
S90.30XA	Black Heel
S60.229A	Black Palm
S00.10XA	Black eye NOS
T15.01XA	Corneal RT Eye Foreign Body
T15.02XA	Corneal LT Eye Foreign Body
T16.1xxA	Ear Foreign Body
S50.00XA	Elbow Contusion
S69.90XA	Wrist/Hand/Finger Injury
S05.90XA	Eye Injury
S09.93XA	Face Injury
S19.9XXA	Neck Injury
S00.93XA	Head Contusion
S60.00XA	Finger Contusion
S60.019A	Thumb Contusion
S50.10XA	Forearm Contusion
S01.80XA	Forehead/Eyebrow Wound
S09.90XA	Head Injury
S70.00XA	Hip Contusion
S80.00XA	Knee Contusion
S99.919A	Ankle Injury
873.1	Scalp Laceration Complicated
873.0	Scalp Laceration Uncomplicated
S41.009A	Arm Wound
S61.409A	Hand Wound
S61.209A	Finger Wound
S81.809A	Lower Leg Wound
S91.309A	Foot Wound
S40.019A	Shoulder Contusion
S49.90XA	Shoulder/Upper Arm Injury
S70.10XA	Thigh Contusion
S93.409A	Ankle Sprain
S23.9XXA	Thorax Sprain
S93.429A	Ankle Deltoid Ligament Sprain
S53.409A	Elbow Sprain
S93.609A	Foot Sprain
S63.90XA	Hand Sprain
S63.509A	Wrist Sprain
S73.109A	Hip Sprain
S83.90XA	Knee Sprain
S33.5XXA	Lumbar Spine
S93.529A	Metatarsophalangeal Sprain
S13.4XXA	Cervical Spine Sprain
S43.409A	Shoulder Sprain
S03.4XXA	Jaw Sprain
S23.3XXA	Thoracic Spine Sprain

** A 7th character is added to S code category:

A Initial encounter
D Subsequent encounter
S Sequela

2.2. External Cause Codes (S - Y codes)

2.2.a. For external causes of injury, poisoning and adverse reactions, the ICD-10-CM classification contain S - Y -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. ICD-10 external codes have been incorporated into a single alpha-numeric code set and begin with V, W, X, or Y. Some ICD-10 codes have an "x" or several "x's" either embedded or at the end of the code to accommodate specific diagnosis and external cause categories created in the future. Documentation should include the date and circumstances surrounding the injury.

2.2.b. The 7th alpha character in an ICD-10 code specifies whether external cause code is related to the initial encounter (A), subsequent (D), or a sequel (S) of the injury. "Sequela" is equivalent to a "late effect." All external cause codes (V, W, X, or Y) have sequela codes.

2.2.c. Use Y – external cause codes only during the first patient visit to the MTF for the injury. External cause codes are not used on follow-up visits UNLESS the injury is war-related. For war-related injuries, the external cause code is used at all follow-up visits.

2.2.d. External cause codes are located at the end of the alphabetic index in the ICD-10-CM book in Volume 2. Like the diagnosis codes, external cause codes have a hierarchical organization. Table 2.2 contains frequently used external cause in OEM.

2.2.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 external cause code as a secondary diagnosis.

2.2.f. An ICD-9 code may have many possible ICD-10 equivalents. Because there are so many more ICD-10 codes than ICD-9 codes, **it is impossible to develop a reliable one-to-one external cause code crosswalk**. Enter the first three characters of the ICD-10 code in AHLTA to search the code range for the code category. Some of the most common OEM external cause codes can be found in Table 2.2.

Table 2.2 External Cause Codes Used Frequently in OEM

External Cause	Y Code
Accident by Caustic/Corrosive substance	T category (found in Table of Drugs)
Accident by Hot Liquid/Vapors or Steam	Contact with heat and hot substances (X10- X19)
Accident by Hot Substance/Object	"
Accident occurring at place of work	Y92.69
Accident occurring in parking lot	Y92.89
Accident Poisoning by Arsenic	Found in Table of Drugs
Accident Poisoning by Lead	T56.OX1
Accident Poisoning by Mercury	T56.1X1
Accident Poisoning by Metals	T56.91
Cause-Electric Current	W86.8
Cause-Other Hand Tools/Implement	W27.8XXA
Cause-Other Powered Hand Tools	W29.8XXA
Excessive heat-weather/man-made	W92.xxxA
Fall from chair	W07.XXXA
Fall into hole other opening	W17.2
Fall-slipping, tripping & stumbling	W18.09
Foreign body in eye & adnexa	T15.xxx-
Hornet, wasp & bee stings	T15.xxx-
Human Bite	W50.3xxA
Hypodermic needle stick accident	W46.0xxA W46.1xxA (contaminated)
Lifting machine and appliance	W24.0xxA
Metal working machine	W31.2xxA
Motor vehicle collision NOS	V00.xxxA – V99.xxxA
Other spec air transport accidents	V95. - V97.

External Cause	Y Code
Other specified machinery	W31.89xA
Overexert/strenuous movement from pull, lift & pushing	Y93.
Struck accidently by falling object	W20.8xxA
Woodworking & forming machine	W31.2xxA

Table 2.3 War Related External Cause Codes

External Cause	Y Code	External Cause	Y Code
Injury due to war operations from rubber bullet (rifle)	Y36.410A	Injury due to war ops from pellet (rifle)	Y36.420A
Injury due to war ops from bullet	Y36.430A	Injury due to war ops by aerial bomb explosion	Y36.210A
Injury due to war ops from bullet and pellet fragments from roadside improvised explosive device (IED)	Y36.430A	Injury due to war ops by guided missile explosion	Y36.220A
Injury due to war ops by explosion of marine torpedo	Y36.040A	Injury due to war ops by mortar	Y36.290A
Injury due to war ops by explosion of marine depth charge	Y36.010A	Injury due to direct or indirect pressure or air blast from a vehicle-borne IED	Y36.230A
Injury due to war ops by explosion of marine mines	Y36.020A	Injury due to war ops struck by blunt object	Y36.450A
Injury due to direct or indirect pressure or air blast from a person-borne IED	Y36.230A	Injury due to war ops but occurring after cessation of hostilities by explosion of mines	Y36.810A
Injury due to war ops by destruction of aircraft due to enemy fire or explosives	Y36.110A	Injury due to war ops by laser	Y36.7X0A
Injury due to war ops by direct blast effect of nuclear weapons	Y36.510A	Injury due to specified form of unconventional warfare	Y36.7X0A
Injury due to war ops from gasoline bomb	Y36.90XA	Injury due to unspecified form of unconventional warfare	Y36.7X1A

2.3. Z Codes

2.3.a. OEM services frequently provide care to workers without specific symptoms or diagnoses, such as medical surveillance or job certification exams. The Z-code classification is provided to deal with occasions when something 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-10-CM codes, called Z-codes, describes the medical necessity of preventive and administrative care.

2.3.b. Z-codes are a separate section of the tabular index of the ICD-10-CM Manual, Volume 1. Like the injury and illness codes, additional digits add specificity to the code.

2.3.c. Z-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.

2.3.c.1. As of 1 Oct 2015, the Military Health System has implemented Unique Codes to add an even greater level of detail for occupational examination data collection. These codes begin with 'DoD,' have 7 characters, and no decimal. See Table 1.2.

2.3.c.2. Z02.79 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, if a patient's reason for an encounter is solely to obtain a medical certificate and no other code more appropriately reflects the primary reason for the encounter, use Z02.79 and appropriate E&M office level if the provider does not evaluate or treat any symptoms, conditions, or diseases.

Table 2.4 V-Codes For Occupational Examinations

Type of Service	V-Code	E&M Code	CPT Code
Occupational exam, initial and recurring, no symptoms	***[DoD0214]*** ***[DoD0215]*** ***[DoD0216]*** ***[D0D0224]***	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	***[DoD0219]*** ***[DoD0220]*** ***[DoD0221]*** ***[DoD0227]*** ***[DoD0228]***	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	Exam xxx.xx Symptom or disease ***[Same as above]***	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)	Exam xxx.xx Symptom or disease ***[Same as above]***	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		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.

2.3.d. Visits including preventive counseling and education, such as a reproductive hazard evaluation, require Z-codes to describe medical necessity of the education or counseling provided. These codes are secondary codes to the appropriate primary diagnostic or other Z-codes. Table 2.5 provides some helpful secondary Z-codes for describing these visits. (Note: Z30.09 is under contraceptive management and should not be used for "counseling" unless done as part of family planning.)

Table 2.5 Secondary V-codes for OEM Education and Counseling

V-code	Education Topic
Z71.89_	Occupational Exposure Education
Z71.89_	Travel Medicine Education
Z56.9_	Occupational Stress Education
Z65.8	Dissatisfaction W/Employment
Z77.090	Exposure to Asbestos
Z57.8	Exposure to Hazardous Body Fluid
Z92.3	Exposure to Irradiation
Z77.011	Exposure to Lead
Z01.00/Z01.01	Eye & Vision (SCP) (Z01.00 - without abnormal findings/Z01.01 – with abnormal findings)
Z71.89_	Injury Prevention
Z71.3	Nutritional Counseling
Z33.1	Pregnancy Incidental
Z31.69	Reproductive Concerns/Hazard
Z13.89	Submarine Pressure Screening

2.3.e. Table 2.6 summarizes diagnostic coding of hearing tests in conjunction with the Hearing Conservation Program. Civilian ICD-10-CM coding guidelines limit both Z02 and Z01 codes to first-listed status and use of code Z02.x therefore typically should exclude Z01.0x. However, the Department of Defense (DoD) 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 2.6 V-codes for Hearing Conservation Program Exams

Encounter Type	ICD-10-CM
Military Accession Exam – No Abnormalities	*
Military Accession Exam – Abnormalities	**R94.120
Baseline Exam – No Abnormalities	*[DOD0214]* * Z01.110
Baseline Exam – Abnormalities	*[DOD0214]*
Annual Exam – No Identified STS	*[DOD0215]*
Annual Exam – Initial STS	*[DOD0215]* *
Annual Exam – Previously Confirmed PTS	*[DOD0215]*
Follow-up 1 or 2 For STS	R94.120
Termination Exam	*[DOD0216]*

*(pending clarification).

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

2.3.f. For individuals receiving occupational audiology evaluation after an abnormal screening evaluation, Z codes with unique code in Table 2.4 apply.

Table 2.7 Code Extenders for Occupational Audiology Evaluations

Encounter Type	ICD-10-CM Code
Examination of Ears and Hearing	Z01.1
Hearing Examination Following Failed Hearing Screening	_0 Z01.110_
Hearing Examination Following Failed Hearing Screening, Otoscopic Exam Done	"
Hearing Examination Following Failed Hearing Screening, Otoscopic Exam Not Done	"
Other Examination of Ears and Hearing	Z01.10 (W/O ABN FINDINGS, Z01.118 W/ ABN FINDINGS)
Other Examination of Ears and Hearing, Otoscopic Exam Done	
Other Examination of Ears and Hearing, Otoscopic Exam Not Done	

2.3.g. For individuals receiving immunizations as required by medical surveillance, the Z codes in Table 2.8 through Table 2.12 apply.

Table 2.8 V-codes for Immunizations

Immunizations *Vaccines or Medication Name*	ICD-10-CM V-code	Administration CPT Code	CPT/HCPCS Code
Anthrax	Z23	90471/90472 each add vaccine	90581
B-12	E53.8 or per MD order	96372	J3420
Chicken Pox (Varivax) Varicella	Z23	90471/90472	90716
Depo Provera 1 mg	Z30.49	96372	J1050
DTaP < 7 yrs	Z23	90471/90472	90700
DT, Pediatric, <7 yrs.	Z23	90471/90472	90702
Flu Shot, split virus 6-35 mos.	Z23	90471/90472	90657
Flu Shot, split virus >3 yrs.	Z23	90471/90472	90658
Flu Mist (intranasal)	Z23	90471/90472	90660
Hep A, 1-18 years, 2 Dose Schedule	Z23	90471/90472	90633
Hep A, Adult	Z23	90471/90472	90632
Hep B, 0-19 years, 3 Dose Schedule	Z23	90471/90472	90744
Hep B, Adult, 20+	Z23	90471/90472	90746

Immunizations *Vaccines or Medication Name*	ICD-10-CM V-code	Administration CPT Code	CPT/HCPCS Code
HPV – Gardasil V04.89	Z23	90471/90472	90649
Twinrix, Hep A & Hep B, Adult	Z23	90471/90472	90636
HIB (3 dose vaccine) PRP – OMP	Z23	90471/90472	90647
IPV (Polio) IM or SUBQ	Z23	90471/90472	90713
JEV (Japanese Encephalitis Virus)	Z23	90471/90472	90735
Meningococcal (2-10 yrs. old) **Menemune**	Z23	90471/90472	90733
Meningococcal (10 yrs. or older) **Menactracon**	Z23	90471/90472	90734
MMR	Z23	90471/90472	90707
MMRV (ProQuad)	Z23	90471/90472	90710
Pediarix (DTaP, IPV, Hep B)	Z23	90471/90472	90723
Pneumococcal, conj. <5 yrs.	Z23	90471/90472	90669
Pneumovax, Adult or immunosuppressed patient	Z23	90471/90472	90732
PPD Placement (TB test)	Z11.1		86580
PPD – Read NEGATIVE	Z11.1		
PPD – Read POSITIVE	1 R76.11		
Rabies IM	Z23	90471/90472	90675
Rotavirus 3 Dose Sched, Live, for Oral use	Z23	90473	90680
Synagist (Per 100mg vial)	Z23	90771	90378
Td, Adult >7	Z23	90471/90472	90718
Tdap IM >7 yrs and older V06.1	Z23	90471/90472	90715
Tetanus toxoid	Z23	90471/90472	90703
Typhoid IM (ViCPs)	Z23	90471/90472	90691
Typhoid Oral	Z23	90473	90690
Yellow Fever	Z23	90471/90472	90717
Zoster (Shingles) SUBQ	Z23	90471/90472	90736
PERSERVATIVE FREE (PF)			
Flu Shot, split virus 6-35 mos., PF	Z23	90471/90472	90655
Flu Shot, split virus >3, PF	Z23	90471/90472	90656
Tetanus and Diphtheria toxoids (Td) age >7, PF	Z23	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 2.9 V-codes for Immune Globulins

Immune Globulin	ICD-10-CM V-code	Administration CPT Code	CPT/HCPCS Code
Immune Globulins (Ig) IM	Z23	96372	90281
Respiratory syncytial virus immune globulin (RSV-IgIM) PER UNIT 50 mg	Z23	96372	90378
Tetanus Immune Globulin (TIg) IM 01 PFS	Z23	96372	90389
Rabies Immune Globulin (Rig-HT), HT 10 1vi	Z23	96372	90376
SHOT TRANSCRIPTION ON TO SPECIAL FORM – such asPH731/State SchPE Form etc.			
Special Reports/Forms	Z02.79		99080

Table 2.10 V-codes for Smallpox Vaccine

Smallpox Vaccine	ICD-10-CM V-code	Administration CPT Code	CPT/HCPCS Code
Smallpox ($202 vial)	Z23		90471/90472
Provider supervised Group Education Service (DoD required briefing)	Z71.89 with extender code		99411 approx. 30 mins 99412 approx. 60 mins
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	Z71.89 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 2.11 E Codes for Vaccine Adverse Events

ICD-10-CM Code	ADVERSE EFFECTS – Nurses use if initiating VAERS (Vaccine Adverse Event Reporting System)	CPT/HCPCS Code
T50. Category *	Diphtheria	99080
	Mix (combination)	99080
	Pertussin	99080
	Tetanus	99080
	Measles	99080
	Lyme's Vic	99080
	Mumps	99080
	Polio	99080
	Rabies	99080
	Typhoid	99080
	Yellow Fever	99080
	Smallpox	99080
	Bacterial, other and unspecified	99080
	Other-unspecified vaccines and biological substances	99080

*ICD-10 T50. Category codes replace ICD-9 codes E 948.- and E949 in the table above.

Table 2.12 V-codes for Vaccine Non-completion

ICD-10-CM Code	Vaccination Non-Completion Event	CPT/HCPCS Code
Z28.9	Vaccination not carried out, unspecified reason	99080
Z28.01	Vaccination not carried out because of acute illness	99080
Z28.02	Vaccination not carried out because of chronic illness or condition	99080
Z28.03	Vaccination not carried out because of immune comprised state	99080
Z28.04	Vaccination not carried out because allergy to vaccine or component	99080
Z28.82	Vaccination not carried out because of caregiver refusal	99080
Z28.21	Vaccination not carried out because of patient refusal	99080

ICD-10-CM Code	Vaccination Non-Completion Event	CPT/HCPCS Code
V28.07	Vaccination not carried out for religious reasons	99080
Z28.81	Vaccination not carried out because patient had disease being vaccinated against	99080
Z28.89	Vaccination not carried out for other reason	99080

3.13 DoD Diagnosis Extender Codes *[DoD Unique Codes]*DoD extender codes are paired with selected *Z* codes to further specify military unique services. The addition of DoD extender codes to the root code enables differentiation of the types of occupational assessments when used in conjunction with the appropriate ICD code. In an effort to collect data to a higher level of specificity, the MHS has added Unique Codes to be used in conjunction with ICD-10-CM codes See Table 1.2.

Aviation Exam
[DOD0217] [Aviation Occupational Exam, Long; or]
[DOD0218] [Aviation Occupational Exam, Short]

Periodic Health Assessments (PHA) or Prevention Assessment
[DOD0225][Service Member Periodic Health Assessment (PHA)/Exam]

Occupational exam
[DOD0214] [Occupational Health Exam -Baseline: Used to establish baseline prior to occupational workplace exposure. Includes Hearing Conservation Program.]
[DOD0215] [Occupational Health Exam - Periodic: Used for continued surveillance for occupational workplace exposure. Includes Hearing Conservation Program.]
[DOD0216] [Occupational Health Exam – Termination: Used for termination of occupational workplace exposure. Includes Hearing Conservation Program.]
[DOD0224] [Occupational Health Exam – Personnel Reliability Program (PRP)]

Duty Status Determination (MEB) assessments, and return to duty following pregnancy or surgery and treatment.
[DOD0219] [Occupational Evaluation, Disability Evaluation System]
[DOD0220] [Occupational Evaluation, Medical Evaluation Board]
[DOD0221] [Occupational Evaluation, Physical Evaluation Board]
[DOD0227] [Occupational Exam/Assessment, Fetal Protection Program]
[DOD0228] [Exam/Assessment, Temporary Disability Retired List Program]

Special Program Accession Encounter
[DOD0229] [Exam for DoD Medical Exam Review Board (e.g., for entry into a Uniformed Services Academy)]

Separation/Termination/Retirement Exam
[DOD0222] [Retirement from Military Service Exam, Long]

Health Exam of defined subpopulations
[No corresponding Unique Code]

Abbreviated Separation/Termination/Retirement Exam
[DOD0223] [Retirement from Military Service Exam, Short]

Physical Readiness Test (PRT) Evaluation
[DOD0226] [Occupational Exam, Service Member participation in physical fitness training or testing]

Pre-Deployment Assessment: Documented on DD2795
[DOD0211] [Assessment, pre-deployment, documented on DD2795]
Initial Post-Deployment Assessment: Documented on DD2796.
[DOD0212] [Assessment, post-deployment, documented on DD2796]

Post Deployment Health Reassessment (PDHRA): Documented on DD2900.
[DOD0213] [Assessment, post deployment, documented on DD2900 (PDHRA)]

Other Exam Defined Population
[No Corresponding Unique Code]

Coding For Privileged Provider Services

2.4. Evaluation and Management Categories in OEM

2.4.a. 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.

2.4.b. Different categories of E&M codes apply to different types of visits. Table 2.13 outlines the E&M categories pertinent to OEM clinics.

Table 2.13 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

2.5. Problem-Oriented Evaluation and Management Services

2.5.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. Section 4 addresses use of the minimal level of service code by support staff.

2.5.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.

2.5.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 2.9). 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.

2.5.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.

2.5.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 8). Section 7 provides expanded information on the history exam and medical decision making components.

2.5.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 8. 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.

2.6. Preventive Medicine Services

2.6.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.

2.6.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.

2.6.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-10-CM Z-code. Then, use a problem- oriented service E&M with modifier -25 linked to the injury and illness ICD-10-CM code describing the symptom, sign, or diagnosis. Table 2.14 provides guidance in differentiating problem-oriented, preventive medicine, and combined visits.

Table 2.14 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 (PFSHx)	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

2.6.d. Code the diagnoses, symptoms, or signs discovered during a preventive services visit which do not require significant time and resources to support a problem focused E&M as secondary ICD-10-CM codes.

2.7. Preventive Medicine Counseling Services

2.7.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.

2.7.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.

2.7.c. Levels for these E&M codes depend on the amount of time that the provider spends with the individual or group. See Table 2.13.

2.7.d. ICD-10-CM codes for these encounters are Z-codes described in Section 2.

2.8. Case Management Services

2.8.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).

2.8.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.

2.8.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.

2.8.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.

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

2.8.f. Medical Team Conference codes:

2.8.f.1. 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.

2.8.f.2. 99367 - Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; PARTICIPATION BY PHYSICIAN.

2.8.f.3. 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.

2.9. Prolonged Services

2.9.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.

2.9.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.

2.10. Special Services

2.10.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.

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

2.10.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.

2.11. CPT Procedure Codes

2.11.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.

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

Table 2.15 outlines some of the more common procedural codes used in conjunction with OEM problem-oriented and preventive visits.

Table 2.15 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

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

2.11.d. EKGss 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 uses 93005 for the tracing only. The provider privileged to interpret and report the 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.

2.11.e. Table 2.16 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 2.16 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

2.12. Other Services

2.12.a. A telephone call initiated by an established patient to a privileged provider, to include Independent Duty Corpsmen (IDCs) 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.

2.12.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.

2.12.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.

2.12.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 7.

3. Coding For Support Staff Services and Supplies

3.1. Occupational Health Nurses and Technicians

3.1.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.

3.1.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-10-CM diagnostic code facilitates AHLTA documentation of the encounter.

3.1.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.

3.1.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.

3.1.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.

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

3.1.f.1 TB test reading.

3.1.f.2. Patient who presents for an order for pregnancy test only.

3.1.f.3. Blood pressure checks per patient request.

3.1.f.4. Patient who presents to pick up a prescription refill.

3.1.g. CPT procedure codes for support staff include those in Table 3.1. 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 3.1 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

Description of Code	CPT Code
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

3.2. Durable Medical Equipment and Supplies

3.2.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 3.2 lists some commonly used equipment and supplies. Again, develop consistent procedures to ensure maximal coding of services provided.

Table 3.2 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

3.2.b. HCPCS Level II also encompasses some privileged provider services not included in the CPT procedure codes. Table 3.3 provides some common examples.

Table 3.3 HCPCS Level II Service Codes Commonly Used in OEM

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

4. AHLTA and Coding

4.1. AHLTA Coding Features

4.1.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-10-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-10-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.

4.1.b. The manual 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).

4.1.b.1 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-10-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.

4.1.c. 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 Subjective/Objective 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.

4.1.d. 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.

5. Coding Scenarios

5.1. Example Coding Scenarios Described and Explained

5.1.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-10-CM:	Occupational Exam	**V70.5_3** *[DOD0215]*
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**

5.1.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-10-CM: Open wound of right hand, w/o complication		**S61.411**
	Cause – Other hand tool/implement	**W27.8xxA**
	Accident occurring in industrial workplace	**Y92.69**
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.

5.1.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-10-CM:	Occupational exam	**V70.5_3** ??? , *[DOD0215]*
	Pericardial pain	**R07.2**
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

5.1.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-10-CM:	Open Wound Finger,	S61.209A Uncomplicated
	Accidents by needle stick	**W46.0xxA**
	Accident occurring in workplace	Y92.69
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.

5.1.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-10-CM:	Other Specified	Z02.89 Administrative service
E&M:	Unlisted E&M Service	**99499**
CPT:	Screening test of visual acuity	**99172/3**

5.1.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-10-CM:	Counseling For Injury Prevention	**V65.43**
E&M:	Support Staff E&M	**99211**
CPT:	N/A	

5.1.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-10-CM:	PHA	**?? ,** *[DOD0225]*
	Inappropriate diet and eating habits	**Z72.4**
E&M:	Preventive Medicine Counseling	**99402**
CPT:	N/A	

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

Coding:

ICD-10-CM:	Medical Certificate	**Z02.79**
	Medical Problem(s)	xxx
E&M:	Preventive Medicine	**99385-99397**
CPT:	N/A	

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

Coding:

ICD-10-CM:	Physical Readiness Test (PRT) Eval	**V70.5_C** *[DOD0226]*
	Medical Problem(s)	XXX
E&M:	Other Preventive Medicine	**99420**
CPT:	N/A	

5.1.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-10-CM:	Physical Readiness Test (PRT) Eval	**V70.5_C** *[DOD0226]*
	Medical Problem(s)	xxx.xx
E&M:	Other Preventive Medicine	**99420**
CPT:	N/A	

6. 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 6.1 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	1 From Each

7. 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, respirations, temp, height, weight)
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

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

8.1. Measuring Medical Decision Making

8.1.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 catheterization or echo)	1
Review/order medical tests (PFTs, EKG, echo, catheterization)	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 8.1 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

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

Table 9.1 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 9.2 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

10. Coding OEM Exams

Table 10.1 Coding OEM Exams

OH Exam Type	Description	Diagnosis (ICD-10-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** **??** , *[DOD0214], [DOD0215], [DOD0216], [DOD0224]* **Secondary** **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** **Z02.79** **Secondary** Diagnosis codes for pertinent medical problems			
Vehicle Exam	Commercial Driver, Explosive Handler/ Vehicle Operator, Forklift, Weight Handling Equipment Operator	**Primary** **V70.5_3 ??** , *[DOD0214], [DOD0215], [DOD0216], [DOD0224]* **Secondary** Diagnosis codes for pertinent medical problems			
Fitness for Duty/ Suitability	Evaluation of worker to assess fitness to return to work	**Primary** **?? ?** *[DOD0219], [DOD0220], [DOD0221], [DOD0227], [DOD0228]* **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**		N/A
Reproductive Toxicity Evaluation	Assessing/communicating reproductive risks in a job	**Primary** **??** , *[DOD0219], [DOD0220], [DOD0221], [DOD0227], [DOD0228]* **Secondary** **Z33.1** (Pregnant)	**New Patient** **99385** (18-39) **99386** (40-64)		

OH Exam Type	Description	Diagnosis (ICD-10-CM Code)	Primary E&M Code	Secondary E&M Code	Procedure (CPT) Code(s)
			99387 (65+) **Established Patient** **99395** (18-39) **99396** (40-64) **99397** (65+)		
Hearing Loss Medical Evaluation	Evaluation for work-relatedness and/or impairment	**Primary** **??** , *[DOD0219], [DOD0220], [DOD0221], [DOD0227], [DOD0228]* **Secondary** Diagnosis codes for pertinent medical problems			
Military Physical Exam	Military physicals including PEB exams (Not separation/ retirement)	**Primary** **??** (Periodic Exam) (Flight Physical; or (PEB Exam) *[DOD0219], [DOD0220], [DOD0221], [DOD0227], [DOD0228]* **Secondary** Diagnosis codes for pertinent medical problems			**G0102** Prostate 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** **Secondary** Diagnosis codes for pertinent medical problems			
MSC physical Exam	Military Sealift Command pre-employment or periodic exams	**Primary** (Pre-employment) *[DOD0214], [DOD0215], [DOD0216], [DOD0224]* (Periodic) *[DOD0225]* **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** (Pre-employment) (Post- deployment) **Secondary** Diagnosis codes for pertinent medical problems			
Special Case – Combined Problem and	Patient appointment for preventive exam,	**Primary**			

OH Exam Type	Description	Diagnosis (ICD-10-CM Code)	Primary E&M Code	Secondary E&M Code	Procedure (CPT) Code(s)
Preventive Visit	medical problem(s) requiring additional evaluation & management addressed	**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 Cessation (3-10) **99407-25** Smoking Cessation (11+)	
Asbestos CXR F/U	Visit for follow-up of abnormal asbestos surveillance CXR	**Confirmed Asbestosis J61** **Non-Specific CXR finding**			
Multiple Exams in same category	For example, multiple vehicular-type exams (e.g., DOT and forklift) Complicated – only use same V-code once.	**Primary** **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

11. Abbreviations

AHLTA - Armed Forces Health Longitudinal Technology Application
AMA - American Medical Association
CPT - Current Procedural Terminology
DoD - Department of Defense
E&M - Evaluation and Management
GINA – Genetic Information Nondiscrimination Act
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
IDC - Independent Duty Corpsman
IED - Improvised Explosive Device
MHS - Military Healthcare System
MTF - Military Treatment Facility
OEM - Occupational Environmental Medicine
PFSHx - Past, Family, and Social History
ROS - Review of Systems
RVU - Relative Value Units
VAERS - Vaccine Adverse Event Reporting System

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