CPT Clinical Record Review Tool Instructions

The (Office of Chief Public Health Nurse (OCPHN) Nurse Consultants have a new Clinical Record Review Tool and will begin utilizing it in 2022 (FY 2022-2023). The purpose of this tool is to guide Local Health Departments (LHDs) in conducting internal record reviews and for PHNPDU Consultants to conduct record reviews, ensuring patient record documentation supports CPT code selection. This tool was adapted from HCPro Boot Camp and is based on the AMA CPT new guidance for "Office and Other Outpatient Visit" (codes 99202-99215), that was made effective January 1, 2021.

It is recommended that you receive training in coding/documentation guidelines for CPT codes 99202-99215 prior to use of this tool. This training is provided by your PHNPDU Nurse Consultant. Otherwise, guidance on Evaluation and Management Services, can be found in the 2022 AMA CPT Codebook.

Instructions for using the Review Tool

Medical Decision Making (MDM) as basis for code selection:

1. On page 1, at top of tool complete the following:
    - Patient name/ID: First and last name and unique patient identification number
    - Chief Complaint: Reason for visit
    - Clinician: Provider conducting and coding the visit
    - Date of visit
    - Carrier: Insurance coverage
2. The first column of table, "Level of MDM/Code", lists overall levels of MDM (RN, Straightforward to High), and respective codes (99202-99205 and 99211-99215).
3. The following 3 columns (elements) will be used to determine overall level of MDM and CPT Code selection for the encounter. See Column descriptions below.
4. Column #1 (Type/Number of Problems): Select level for type and/or number of Problems addressed at the encounter and check appropriate box. Selection based on ICD-10 code(s) selected by provider or Qualified Health Care Provider (QHP) for the visit, as well as descriptors given in CPT codebook. Levels range from Minimal to High.
5. Column #2 (Complexity of Data): Select level of complexity of Data reviewed or analyzed at the encounter. Levels range from Minimal to Extensive. See Column #2A to determine selection for this column.
6. Column #2A (Categories): Check appropriate box based on what data was reviewed or analyzed. Select category or combination of categories based on specific definitions and criteria listed.
7. Column #3 (Risk of Complications): Select level of Risk of complications and/or morbidity or mortality of patient management (treatment). Check appropriate box for level of risk of patient management options. Levels range from Minimal to High.
8. Once level (Minimal to Extensive/High) has been selected for all 3 columns, turn to page 2 of Record Review Tool.
9. Insert Problem, Data and Risk scores (level) from table on page 1 of tool.
10. Determine Final MDM score (level) based on the 3 MDM elements (problems, data, risk). To qualify for a particular level of MDM, 2 of the 3 elements for that level must be met or exceeded.

11. Select Final MDM score on grid with codes listed.
12. Skip to bottom of page and note whether History and Physical Exam were documented on the encounter or not.
13. Note whether Physician/QHP signed record or not.
14. Note original code selected (by provider) and whether reviewer (you) agree or not.
15. Place "correct" code, or code level you scored after review of record.
16. Reviewer should sign name and insert date of your review.

(Time (total Time) as basis for code selection:

1. At top of tool on page 1 complete the following:
    - Patient name/ID: First and last name and unique patient identification number
    - Chief Complaint: Reason for visit
    - Clinician: Provider conducting and coding the visit
    - Date of visit
    - Carrier: Insurance coverage
2. Turn to page 2 of tool and use Time-based coding section to determine code level of visit.
3. Determine if patient is New or Established and use appropriate grid. Definition of new/established can be found in the CPT Codebook.
4. Check appropriate code level based on Total time for activities by Physician/QHP for individual encounter. Total time must be documented in record to use as basis for code selection.
5. Using chart at bottom of page 2, note if Prolonged Service codes (for prolonged time) were used and reported. Prolonged Service codes should ONLY be used with time-based coding, and in conjunction with highest level CPT codes 99205/99215. The CPT code book gives guidance on using AMA code 99417 and HCPCS Level II book gives guidance on using CMS code G2212 (Medicare patients).
6. Note whether History and Physical Exam were documented on the encounter or not.
7. Note whether Physician/QHP signed record or not.
8. Note original code selected (by provider) and whether reviewer (you) agree or not.
9. Place "correct" code, or code level you scored after review of record.
10. Print and sign name and insert date of your review.

Guidelines for Office or Other Outpatient E/M Services:

See the following references for guidelines, definitions, and clarification:

- Level of Medical Decision Making (MDM)
    - Elements of MDM definitions (2022 AMA CPT Codebook, pages 13-15)
    - Table 2: Levels of MDM Grid (2022 AMA CPT Codebook, pages 17-18)
- Total Time for activities by Physician/QHP on date of encounter
    - Definitions for using Time (2022 AMA CPT Codebook, pages 7-8)
    - Definitions for Provider/QHP (2022 AMA CPT Codebook /Introduction, page xiv)
- Medically appropriate history and/or physical exam should be performed

- Physician or QHP reporting the service determines the "nature and extent" of the history and/or physical exam (2022 AMA CPT Codebook, pages 13-15)

➢ Codes used:

- New patients: 99202, 99203, 99204, 99205
- Established patients: 99212, 99213, 99214, 99215
- Definitions for New vs Established patients (2022 AMA CPT Codebook, page 6)

All documentation within medical records/electronic health record should be complete, clear, and legible for every patient encounter. Provider documentation should support/justify level of code selection. Please reach out to your PHNPDU Nurse Consultant for questions or further guidance and training. We are here to help you be successful!