99202

Scenario #1: 99202

LEFT KNEE PAIN

Provider Documentation

Visit Type:

New patient

Chief Complaint:

Patient presents today with a new concern of left knee pain.

The patient is a 32-year-old, male who presents today for an evaluation of his left knee. About a month ago, he began to feel medial and lateral knee pain and followed up with a walk in clinic. He was provided with an IM injection, which provided a few weeks of relief. The pain is described as a sharp pain. Sometimes, the knee will pop. It was thought that he may have a meniscal tear. He cannot recall any injury. Exercising on an elliptical will exacerbate his symptoms. He denies having any back or hip pain and also denies having any numbness or tingling distally. Over the past 10 days since he made this appointment, the symptoms have resolved.

Exam:

- Gait: normal, non-antalgic.
- Ecchymosis - Left: none.
- Effusion - Left: none.
- Swelling - Left: none.
- Maximum tenderness - Left: non-tender.
- Patella exam - Crepitation - Left: none.
- Knee ROM: PROM - Flexion: 135 degrees, Extension: 0 degrees.
- Neurological: No evidence of sensory loss in the affected area.
- X-rays obtained today were reviewed with the patient. There is a possibility that his symptoms are related to chondromalacia patella. He is not having any patellar tendon symptoms. His history is more consistent with a minor sprain that has resolved.

Assessment/Plan:

Given his resolved mechanical type symptoms, I recommend he discontinue his knee wrap and resume walking. If the pain recurs, he will let us know.

Time spent:

15 minutes

Coding

Number and Complexity of Problems addressed:

1 straightforward or minor problem: Straightforward

Amount and/or complexity of data to be reviewed and analyzed:

X-rays (technical and professional components) were separately billed: None

Risk of complications and/or morbidity or mortality of patient management:

Sprain, resolving: Low

Level of MDM based on 2 out of 3 elements of MDM:

Straightforward

Code:

99202

Rationale:

The risk of complications and/or morbidity or mortality of patient management for a sprain is typically Low, which would support Level 3. However, the number and complexity of problems addressed is minimal, and no data contributes to this case because X-rays in the office were separately billed.

Scenario #2: 99202

NEW CONCERN ABOUT A LESION

Provider Documentation

Visit Type:

New patient

Chief Complaint:

Patient presents today with a new concern about a lesion on her shoulder.

History of Present Illness:

Patient states there has been a change in the lesion over the past two years. The lesion worsens with scratching and rubbing. The lesion sometimes disappears and sometimes worsens. No treatment to date.

Review of Systems:

Denies constitutional symptoms. Skin, as stated in HPI.

Past Medical History:

Allergies: NKDA

Family History:

Noncontributory

Social History:

Patient has never smoked.

Exam:

- Constitutional: Appears stated age, healthy and well-developed young woman in no acute distress.
- Eyes: conjunctivae clear, eyelids normal and palpebral fissures equal.
- ENMT: Lips appear normal and healthy. Gums, normal. Palate, normal in appearance. Oropharynx: normal. Oral mucosa, normal with no thrush. Tongue is normal.
- Upper Extremities: Fingers and fingernails are normal. Nail plate is normal.
- Skin: examination of the shoulder area indicates Lentigenes, actinic damage, Seborrheic keratosis.

Assessment:

- Seborrheic keratosis, **L82.1**
- Extensive discussion with the patient about the etiologies, natural history and treatment options regarding seborrheic keratosis and acne.
- Prescription and skin care management recommended. Acanya 1.2 – 2.5% apply to affected area twice a day for eight weeks.
- Will try topical treatment and let us know.

Time spent:

15 minutes

Coding

Number and complexity of problems addressed:

1 self-limited or minor problem: Minimal

Amount and/or complexity of data to be reviewed and analyzed:

None: Minimal or none

Risk of complications and/or morbidity or mortality of patient management:

Prescription management: Moderate

Level of MDM based on 2 out of 3 elements of MDM:

Straightforward

Code:

99202

Rationale:

This visit for a new patient with a straightforward problem and prescription management would support 99202. Under the previous guidelines, the code would have been limited to 99202 due to the expanded problem-focused examination. Under the 2021 guidelines, the detailed history and problem-focused exam do not count toward level of service.

Bonus tip:

The visit included extensive discussion with the patient about the etiologies, natural history and treatment options. Visits can also be coded based on total time spent by the billing provider on the date of service, including pre- and post-service activities, such as review of data (previous medical records and test results) and any coordination of care.