99202

Scenario #1: 99202

SUTURE REMOVAL

Comparative review of 2021 vs. 1995-1997 guidelines

	Scoring using 1995 Guidelines	Scoring using 2021 Guidelines
Chief Complaint: Suture removal		
HPI: This 19 year-old male was seen in the emergency department for a finger laceration 10 days ago. He is attending college nearby and cannot get home to his family physician. Requests suture removal and a note to resume football.	HPI: • Location (finger) • Duration (10 days ago) No review of systems. No past history. No family history. Social history: Attends college.	Document chief complaint and history as required to support medical necessity for the service. No components are scored.
History	Problem-focused	N/A
Physical Exam: Vital signs taken. Temperature 98.6, BP 112/82, Weight 163. Patient is alert and cooperative. The bandage was removed from the right third finger and the area was cleansed thoroughly. Examination of the laceration showed a well-healing 4 cm wound without swelling, erythema. Sutures removed and a new bandage was applied.	• Constitutional • Psych • Integumentary	N/A
Exam	Expanded Problem Focused	N/A

	Scoring using 1995 Guidelines	Scoring using 2021 Guidelines
Assessment: Finger laceration, healing without complication. Given a note to resume football and the patient was reminded to keep the area clean and protect the finger during football. Return prn.	Medical Decision-Making • Self-limited minor problem, 1 point • No data reviewed • Minimal risk • Superficial dressings	Medical Decision-Making • 1 self-limited or minor problem Note: 99201 has been deleted from the CPT manual as of 1/1/2021.
MDM Assessment	**Straightforward**	**Straightforward**
Time Component	20 minutes, statement required that more than half of the face-to-face visit was spent in counseling/coordination of care. A summary of the discussion is required in detail.	N/A
Code level	**99201**	**99202**

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.

