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99203

**DOCUMENTATION REQUIREMENTS**

**Medical Decision Making: low**
- Limited number of diagnoses or management options considered
- Limited amount and complexity of data reviewed
- Low risk of complications or morbidity or mortality

**Problem Severity: moderate**
- Moderate risk of morbidity without treatment
- Moderate risk of mortality without treatment
- Uncertain outcome or increased probability of prolonged functional impairment or increased probability of prolonged functional impairment

**History: detailed**
- Chief complaint
- Extended history of present illness (four or more HPI elements or the status of three chronic problems)
- Extended system review (two to nine systems)
- Pertinent past, family, and/or social history (one of the history areas)

**Examination: detailed**
- 1995: two to seven organ systems or body areas with an extended exam of affected area(s)
- 1997: at least two bullet (*) elements from at least six organ systems or body areas, OR at least 12 bullet (*) elements from two or more organ systems or body areas. Eye and psychiatric single-system exams must include at least nine bullet (*) elements.

**Code Indicators** *(from tables of risk—including some AMA indicators in italic)*

**Presenting Problem(s)**
- Two or more self-limited or minor problem(s)
- One stable chronic illness (e.g., well controlled hypertension or non-insulin-dependent diabetes, cataract, BPH)
- Acute uncomplicated illness or injury (e.g., cystitis, allergic rhinitis, simple sprain)

**Management Options**
- Physical therapy, rest or exercise, diet, stress management
- Over the counter drugs, medication management with minimal risk
- Minor surgery, with no identified risk factors
- Occupational therapy
- IV fluids, without additives

**Counseling and/or coordination of care**
- As appropriate for the problem

**Time Spent Face to Face (average)**
- 30 minutes

**KEY POINT**

The 1995 guidelines indicate that two to seven organ systems or body areas are required. For a detailed exam, at least one of those systems needs to be in more detail as in this example.
Sample Documentation—99203

Level III Initial Office Visit

**Reason for visit:** “Something is really wrong”

**HPI:** This 18-year-old white female complains of vaginal itching, burning, and pain for three days, getting “worse and worse.” She tried an OTC preparation, but it provided little relief. She has never had a GYN exam before and is apprehensive. She has been sexually active for three years, has had four partners and “always” uses condoms for protection. Past history unremarkable. She denies use of tobacco, drugs, or alcohol except for a “beer or two” on weekends. She is a university student, lives in the dorms, works part time at the university. No known allergies. Menses regular, lasting three to four days, normal flow; LMP 10 days ago. No history of STD or previous GU infections. Review of systems otherwise within normal limits.

**Physical exam:** Vital signs: T: 97.8, R: 18, P: 76, BP: 116/78. Abdomen: no organomegaly, no masses or tenderness. External genitalia, red and irritated with a foul-smelling creamy discharge oozing from the vagina; no lesions noted. No adnexal tenderness or ovarian masses. Uterus 8 cm. Cervix firm, pink no discharge from os. Rectal negative. Pap smear deferred. Gram stain of vaginal discharge negative for GC. Wet mount + clue cells. KOH prep revealed no yeast or hyphae.

**Impression:** Bacterial vaginitis.

**Plan:** The patient was reassured, and her condition was explained. She was given an RX for metronidazole gel intravaginally BID x five days, and was also instructed that her partner should be treated concurrently. GC culture and VDRL sent.

(Single organ system—genitourinary-female)

Level III Initial Office Visit

**History:** 41-year-old male complaining of pain, stiffness, “clicking” and swelling of both knees that is of gradual onset but seems to be getting worse. He cannot pinpoint when he first noticed a problem, but it was several months before his move here six months ago. He first noted pain in his knees after exercise but notes that exercise also makes the stiffness better. He occasionally gets nonradiating backache, especially after lifting and doing yard work, but sometimes it happens for no apparent reason. Over-the-counter preparations such as Advil with rest and heat help his back and used to make his knees feel better, but lately they seem worse. He notes no paresthesias from his back. Past history is otherwise noncontributory. He notes no problems with gait or stability.

**Physical Exam:** Well-developed, somewhat obese white male. Height 5’10”, weight 205 pounds. BP 130/92. Gait and station are normal. Back appears normal; no kyphosis or scoliosis; no tenderness upon palpation of the lumbar area. Flexes to 90 degrees. Leg lengths even and joints symmetrical. Knees are nontender and are not erythemic or warm. Full range of motion. No back pain on straight leg raising. McMurray’s negative. There is moderate crepitation noted on movement of the knees. Hip movement is normal and the patient reports no pain. Muscle strength, pulses and reflexes are all within normal limits. Babinski is negative. Normal response to touch and pinprick.

**Impression:**
1. Osteoarthritis, bilateral knees.

**Plan:** Discussion with the patient regarding osteoarthritis, treatment options and nature of the condition. Patient instructed in the importance of daily exercise including stretching exercises to avoid further damage to the joints. Importance of weight reduction in management of DJD was also strongly stressed. Patient was instructed to use aspirin to relieve knee and back pain, and was given a referral for physical therapy evaluation and instructions on exercises and activities to help manage his condition. The patient was instructed to return in four months for follow-up and to call sooner if there are any problems. The patient was advised to contact his PCP for hypertension follow up.

(Single organ system—musculoskeletal)