



## Established Patient 99212 Documentation Requirements

### When reporting for telemedicine

- Modifier -95 may be required depending on the payer
- Place of service is 2, which also may vary by payer

**99212 - Office or other outpatient visit for the evaluation and management of an established patient, which requires two of three of these components. Note: Medical decision making must be one of the two components.**

A problem focused history

- A problem focused examination
- Straightforward medical decision making

Usually the presenting problem(s) are of low severity.

1. ☐ The physician signature is identifiable. If EHR, the physician signature is secure and a signature protocol is available for review.
2. ☐ Each page of the printed or copied record includes patient's name, chart number or other patient identification.

### History

3. ☐ Chief complaint
4. ☐ 1 to 3 elements listed below to meet the history of the present illness requirement

Location	Timing
Context	Quality
Modifying factor	Severity
Duration	Associated signs and symptoms

5. ☐ Review of systems: only as medically necessary.

Eyes	Gastrointestinal
Constitutional	Genitourinary
Ears, nose, mouth, throat	Integumentary
Cardiovascular	Neurological
Respiratory	Musculoskeletal
Hematologic/Lymphatic	Allergic/Immunologic
Psychiatric	Endocrine



6. Documentation of the following only as medically necessary or for MIPS reporting.

- ☐ Past history
- ☐ Family history
- ☐ Social history

### Examination

7. ☐ One to five of the following 12 elements of the exam are performed (if exam is used to establish level of service)

Visual acuity	Ocular adnexa	Lens
Confrontation visual fields	Pupil and iris	Intraocular pressure
Extraocular motility	Cornea	Optic nerve discs
Conjunctiva	Anterior chamber	Retina and vessels

8. ☐ Mental assessment not required. Dilation is not required.

### Medical Decision Making

9. What is the diagnosis? \_\_\_\_\_

10. ☐ The ICD-10 code reflects the highest level of specificity

11. Must meet one of the following criteria:

- ☐ Established or new problem to examiner: stable, improved or worsening
- ☐ Clinical lab test(s): ordered or reviewed
- ☐ Radiology tests: ordered or reviewed
- ☐ Other diagnostic tests: ordered or reviewed
- ☐ Review of old records and/or additional history from other than the patient

12. Must meet one of the two categories:

Presenting Problem(s)	Management Options Selected
<ul style="list-style-type: none"><li>• One self-limited or minor problem</li></ul>	<ul style="list-style-type: none"><li>• Bandage or superficial dressing</li><li>• Observation</li><li>• Home care instructions, i.e. warm compresses, lid scrubs</li></ul>