BCA Recipe Card - Must meet TWO of THREE categories:

Final E/M Code	Problems: Number/Complexity	Data: Amount/Complexity	Risk of Complication
99202/99212 Straightforward	**1** self-limited or minor problem	**None**	**None** Rest, Ice, Elevation
99203/99213 Low	•**2+** Self-limited or minor illness •**1** Stable chronic •**1** Acute uncomplicated	**Limited: 1 of 2 data categories required** •**2** Unique tests or documents **OR** •1 Independent historian assessment	**Low** OTC Meds PT, OT
99204/99214 Moderate	•**1+** Progressing chronic, exacerbation or treatment SE •**2+** Stable chronic •**1** Undiagnosed new problem • **1** Acute illness w/systemic symptoms •**1** Acute complicated injury	**Moderate: 1 of 3 data categories required** •**3** Unique tests,external notes from unique source or ind historian assessment •Test interp not separately reported by clinician •Mgmt discussion or test interp w/external clinician/appropriate source	**Moderate** •Rx drug mgmt •Minor surgery/procedure decision w/patient or procedure risk factors •Major surgery decision w/o identified patient or procedure risk factors •SDoH significantly limiting dx or mgmt
99205/99215 High	•**1+** Chronic illness w/severe exacerbation or treatment SE •**1** Acute or chronic or injury posing a threat to life/ bodily function	**Extensive: 2 of 3 data categories required** •**3** Unique tests,external notes from unique source or ind historian assessment •Test interp not separately reported by clincian •Mgmt discussion or test interp w/external clinician/appropriate source	**High** •Intensive monitoring for drug therapy for toxicity •Elective major surgery decision w/identified patient or procedure risk factors •Emergent major surgery decision •Decision regarding hospitalization •DNR or de-escalation of care d/t poor prognosis

Time-Based Encounters

Final E/M Code	
Established Patient	**Time Range**
99212	10-19 mins
99213	20-29 mins
99214	30-39 mins
99215	40-54 mins
New Patient	**Time Range**
99202	15-29 mins
99203	30-44 mins
99204	45-59 mins
99205	60-74 mins

Allowable Activities for Time performed on date of service

- **Pre-visit work:** Review of lab/test results, consult notes, discharge summary
- **History:** Review of separately obtained history e.g. caregiver, guardian, witness
- **Face to face:** Time spent on medically necessary exam and/or evaluation
- **Education or counseling** of patient/family/caregiver
- **Orders:** labs, xrays, other diagnostic tests or procedures, medications
- **Referral/Communicaton** with other health care professionals
- **Documentation:** clinical information documentation in the EMR/health record
- **Independent Results Interp:** results/communication to patient/family/caregiver
- **Coordination of care** not separately reported

Note: Time spent performing separately reported services, e.g., procedures, EKGs, chronic care management activities, etc. cannot be counted

Reminder: Don't count time by: Ancillary staff, Resident/student, time on another DOS or procedure time