Background

• HCFA, now CMS (Center for Medicare and Medicaid Services) issued guidelines for documentation of different service codes in 1995. They were revised in 1997. Either can be used, but not in combination.

• *In general*, the 1995 guidelines are more favorable for Internists

• Medicaid and commercial payers may or may NOT follow CMS guidelines
Disclaimer

This session will provide basic information regarding documentation and coding.

The rules change constantly.

Be vigilant, or know someone who is vigilant for you.
Session Objectives

• Review Documentation requirements for Basic Outpatient Office Visits
  – Emphasis on 1995 PE guidelines
  – Case-based examples

• Learn efficient documentation of Medical Decision Making

• Review time based coding

• Discuss Annual examinations

• Leave time for Questions
Introductions
Basic Coding Rules and Regulations
Three Questions

• Is the patient new or established?
• What level of history, PE and Medical Decision Making (MDM) is (will be) recorded?
  – Corollary: Is this a problem-based or Annual Exam/Annual wellness visit
• What is the appropriate Service Code for the care documented?
New vs. Return

• A new patient has not received face to face professional services from your group in the past 3 years
  – Your group??
• Hospital = clinic
• Residents = Faculty = Physician extenders
• If established patient has not been seen in 3 years, bill them as New
<table>
<thead>
<tr>
<th>CMS specialty Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 01 General Practice</td>
</tr>
<tr>
<td>• 02 General Surgery</td>
</tr>
<tr>
<td>• 03 Allergy/Immunology</td>
</tr>
<tr>
<td>• 04 Otolaryngology</td>
</tr>
<tr>
<td>• 05 Anesthesiology</td>
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<tr>
<td>• 06 Cardiology</td>
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<tr>
<td>• 07 Dermatology</td>
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<tr>
<td>• 08 Family Practice</td>
</tr>
<tr>
<td>• 09 Interventional Pain Management</td>
</tr>
<tr>
<td>• 10 Gastroenterology</td>
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<tr>
<td>• 11 Internal Medicine</td>
</tr>
<tr>
<td>• 12 Osteopathic Manipulative Medicine</td>
</tr>
<tr>
<td>• 13 Neurology</td>
</tr>
<tr>
<td>• 14 Neurosurgery</td>
</tr>
<tr>
<td>• 15 Speech Language Pathologist in Private Practice</td>
</tr>
<tr>
<td>• 16 Obstetrics/Gynecology</td>
</tr>
<tr>
<td>• 17 Hospice and Palliative Care</td>
</tr>
<tr>
<td>• 18 Ophthalmology</td>
</tr>
<tr>
<td>• 19 Oral Surgery (Dentists only)</td>
</tr>
<tr>
<td>• 20 Orthopedic Surgery</td>
</tr>
<tr>
<td>• 21 Cardiac Electrophysiology</td>
</tr>
<tr>
<td>• 22 Pathology</td>
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<tr>
<td>• 23 Sports Medicine</td>
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<tr>
<td>• 24 Plastic and Reconstructive Surgery</td>
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<tr>
<td>• 25 Physical Medicine and Rehabilitation</td>
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<td>• 26 Psychiatry</td>
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<td>• 27 Geriatric Psychiatry</td>
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<tr>
<td>• 28 Colorectal Surgery</td>
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<tr>
<td>• 29 Pulmonary Disease</td>
</tr>
<tr>
<td>• 30 Diagnostic Radiology</td>
</tr>
<tr>
<td>• 31 Intensive Cardiac Rehabilitation (ICR)</td>
</tr>
<tr>
<td>• 32 Anesthesiologist Assistant</td>
</tr>
<tr>
<td>• 33 Thoracic Surgery</td>
</tr>
<tr>
<td>• 34 Urology</td>
</tr>
<tr>
<td>• 35 Chiropractic</td>
</tr>
<tr>
<td>• 36 Nuclear Medicine</td>
</tr>
<tr>
<td>• 37 Pediatric Medicine</td>
</tr>
<tr>
<td>• 38 Geriatric Medicine</td>
</tr>
<tr>
<td>• 39 Nephrology</td>
</tr>
<tr>
<td>• 40 Hand Surgery</td>
</tr>
<tr>
<td>• 41 Optometry</td>
</tr>
<tr>
<td>• 42 Certified Nurse Midwife</td>
</tr>
<tr>
<td>• 43 Certified Registered Nurse Anesthetist (CRNA)</td>
</tr>
<tr>
<td>• 44 Infectious Disease</td>
</tr>
<tr>
<td>• 46 Endocrinology</td>
</tr>
<tr>
<td>• 48 Podiatry</td>
</tr>
<tr>
<td>• 50 Nurse Practitioner</td>
</tr>
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</table>
### New Patient - outpatient visit

3/3 needed

<table>
<thead>
<tr>
<th>CPT</th>
<th>99201</th>
<th>99202</th>
<th>99203</th>
<th>99204</th>
<th>99205</th>
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<tbody>
<tr>
<td>HPI</td>
<td>1 (PF)</td>
<td>1 (EPF)</td>
<td>4 (DET)</td>
<td>4 (COMP)</td>
<td>4</td>
</tr>
<tr>
<td>ROS</td>
<td>1</td>
<td>2</td>
<td>10</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>PFSH</td>
<td></td>
<td></td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Exam</td>
<td>1 (PF)</td>
<td>2-7* (EPF)</td>
<td>2-7** (DET)</td>
<td>8 (COMP)</td>
<td>8</td>
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<tr>
<td>MDM</td>
<td>Straight-forward</td>
<td>Straight-forward</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
</tr>
<tr>
<td>Time</td>
<td>10</td>
<td>20</td>
<td>30</td>
<td>45</td>
<td>60</td>
</tr>
</tbody>
</table>

*EPF exam: minimal detail; ** Det exam: expanded documentation of organ systems examined (NGS documentation tool)
Coding New Patient Visits

• 3 of 3 elements must be documented (history, exam, decision making)

• MEDICAL NECESSITY SHOULD DRIVE CODING
## Return Patient- outpatient visit

2/3 needed

<table>
<thead>
<tr>
<th>CPT</th>
<th>99211</th>
<th>99212</th>
<th>99213</th>
<th>99214</th>
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<tbody>
<tr>
<td>HPI</td>
<td>1 (PF)</td>
<td>1 (EPF)</td>
<td>4 (3 chronic)</td>
<td>4 (3 chronic)</td>
<td>1</td>
</tr>
<tr>
<td>ROS</td>
<td>1</td>
<td>2 (DET)</td>
<td>1</td>
<td>10 (COMP)</td>
<td>2</td>
</tr>
<tr>
<td>PFSH</td>
<td>Reserved for non-facility-based practice</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exam</td>
<td>1 (PF)</td>
<td>2-7 (EPF)</td>
<td>2-7 (DET)</td>
<td>8 (COMP)</td>
<td></td>
</tr>
<tr>
<td>MDM</td>
<td>Straight-forward</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>10 min</td>
<td>15 min</td>
<td>25 min</td>
<td>40 min</td>
<td></td>
</tr>
</tbody>
</table>
Coding Return pt visits

• Only need 2 of 3 elements documented to meet level of service coded (History, PE, MDM)

• MEDICAL NECESSITY SHOULD STILL DRIVE CODING
Medical Necessity??

- It’s what you should do, not what CAN do

- What the patient needs today, no more and no less

- Generally, (not always) medical decision making matches medical necessity
Standard Documentation

- CC
- History
- PE
- Assessment and Plan
What you are really thinking

• Chief Complaint
• What’s wrong with this patient? (MDM)
  – Possible differential diagnosis
    • #diagnoses or management options
  – What information do I need to gather to figure this out?
    • Amount and complexity of data
  – How quickly do I need to do all of this?
    • risk level to patient

• History
• PE
Documenting Medical Decision Making

The Real Meat of Internal Medicine
Medical Decision Making

• Number of diagnoses
  – Self-limited; established; new problem
  – Stable, worsening, additional testing planned

• Amount/complexity of data reviewed
  – Ordering tests, reviewing tests, obtaining record

• Overall risk of complications
  – See chart
Number of diagnoses

- Self-limited or minor: 1 pt each (2 max)
- Established problem, stable: 1 pt
- Established problem, worsening: 2 pts
- New problem, no addt’l w/u: 3 pts (1 max)
- New problem, with further w/u: 4 pts (Additive)

<table>
<thead>
<tr>
<th>Diagnosis Points</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis MDM</td>
<td>SF</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
</tr>
</tbody>
</table>
### Amount/complexity of data

- Review and/or order lab test: 1 pt
- Review and/or order radiology: 1 pt
- Review and/or order medical test: 1 pt
  - Includes vaccines, ecg, echo, pfts
- Discussion of test w/performing MD: 1 pt
- Independent review of test: 2 pts
- Old records or hx from another person
  - Decision to do this: 1 pt
  - Doing it and summarizing: 2 pts

<table>
<thead>
<tr>
<th>Data points</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data MDM</td>
<td>SF</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
</tr>
<tr>
<td>Category</td>
<td>Example</td>
<td>Risk Level</td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------------------------------</td>
<td>--------------------------------</td>
<td>------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Presenting problem</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dx procedures</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Management options</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Pearls:</td>
<td></td>
<td></td>
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<tr>
<td>Dart Board</td>
<td></td>
<td></td>
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<tr>
<td>Prescription drug management</td>
<td>moderate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2+ stable chronic illness</td>
<td>moderate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abrupt MS change</td>
<td>high</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 chronic illness w/severe</td>
<td>high</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk Level</td>
<td>Presenting Problem(s)</td>
<td>Diagnostic Procedure(s) Ordered</td>
<td>Management Options Selected</td>
<td></td>
</tr>
<tr>
<td>------------</td>
<td>-----------------------</td>
<td>---------------------------------</td>
<td>----------------------------</td>
<td></td>
</tr>
</tbody>
</table>
| Minimal    | • One self-limited or minor problem, e.g., cold insect bite, tinea corporis | • Laboratory tests requiring venipuncture  
  • Chest X-rays  
  • EKG/ EEG  
  • Urinalysis  
  • Ultrasound, e.g., echo  
  • KOH prep | • Rest  
  • Gargles  
  • Elastic bandages  
  • Superficial dressings |
| Low        | • Two or more self-limited or minor problems  
  • One stable chronic illness, e.g., well controlled hypertension or noninsulin dependent diabetes, cataract, BPH  
  • Acute uncomplicated illness or injury, e.g., cystitis, allergic rhinitis, simple sprain | • Physiologic tests not under stress, e.g., pulmonary function tests  
  • Noncardiovascular imaging studies with contrast, e.g., barium enema  
  • Superficial needle biopsies  
  • Clinical laboratory tests requiring arterial puncture  
  • Skin biopsies | • Over-the-Counter drugs  
  • Minor surgery with no identified risk factors  
  • Physical therapy  
  • Occupational therapy  
  • IV fluids without additives |
| Moderate   | • One or more chronic illness with mild exacerbation, progression, or side effects of treatment  
  • Two or more stable chronic illnesses  
  • Undiagnosed new problem with uncertain prognosis, e.g., lump in breast  
  • Acute illness with systemic symptoms, e.g., pyelonephritis, pneumonitis, colitis  
  • Acute complicated injury, e.g., head injury with brief loss of consciousness | • Physiologic tests under stress, e.g., cardiac stress test, fetal contraction stress test  
  • Diagnostic endoscopies with no identified risk factors  
  • Deep needle or incisional biopsy  
  • Cardiovascular imaging studies with contrast and no identified risk factors, e.g., arteriogram cardiac catheter  
  • Obtain fluid from body cavity, e.g., lumbar puncture, thoracentesis, culdocentesis | • Minor surgery with identified risk factors  
  • Elective major surgery (open, percutaneous or endoscopic with no identified risk factors)  
  • Prescription drug management (continuation & new prescription)  
  • Therapeutic nuclear medicine  
  • IV fluids with additives  
  • Closed treatment of fracture or dislocation without manipulation |
| High       | • One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment  
  • Acute or chronic illnesses or injuries that may pose a threat to life or bodily function, e.g., multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure  
  • An abrupt change in neurologic status, e.g., seizure, TIA, weakness or sensory loss | • Cardiovascular imaging studies with contrast with identified risk factors  
  • Cardiac electrophysiological tests  
  • Diagnostic endoscopies with identified risk factors  
  • Discography | • Elective major surgery (open, percutaneous or endoscopic with identified risk factors)  
  • Emergency major surgery (open, percutaneous or endoscopic)  
  • Parental controlled substances  
  • Drug therapy requiring intensive monitoring for toxicity  
  • Decision not to resuscitate or to de-escalate care because of poor prognosis |
# Overall Decision Making Table

need 2 of 3 elements to qualify for given level

<table>
<thead>
<tr>
<th>Level of MDM</th>
<th>Straight-forward</th>
<th>Low</th>
<th>Moderate</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>99201/02, 99212</td>
<td>99203, 99213</td>
<td>99204, 99214</td>
<td>99205, 99215</td>
</tr>
<tr>
<td># dx</td>
<td>1 minimal</td>
<td>2 limited</td>
<td>3 Moderate</td>
<td>4 Extensive</td>
</tr>
<tr>
<td>Amt data</td>
<td>≤1 minimal</td>
<td>2 limited</td>
<td>3 Moderate</td>
<td>4 Extensive</td>
</tr>
<tr>
<td>Risk</td>
<td>minimal</td>
<td>low</td>
<td>moderate</td>
<td>high</td>
</tr>
</tbody>
</table>
Case #1: LBP, New pt

- IMP: Mechanical LBP; R/O HNP
- Plan: Taper off NSAIDs; tylenol prn;
- Xray of LS spine
- Work on Hamstring stretching
- Will call with xray results
- If xray neg, or symptoms persist, will consider MRI of spine to R/O HNP. Pt understands plan.
- Xray results noted (personally reviewed??)
Case #1: LBP PM&R

- Presenting Problems: 1 new with workup 4 points-high
- Data: xray; 1 points- SF
- Risk: OTC meds; exercises: **Low**

<table>
<thead>
<tr>
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<td>high</td>
</tr>
</tbody>
</table>

**Overall:** From MDM perspective: **Low; 99203**
Case #2: Senior Health

Assessments
1. Loss of weight - 783.21 (Primary), good appetite stable with few lb fluctuation
2. Mild cognitive impairment, so stated - 331.83, cognition stable has 24 hr care for safety but has been doing well
3. Abnormality of gait - 781.2, fear of falling afn family requesting further PT
4. Macular degeneration (senile) of retina, unspecified - 362.50, new complaint worrisome and needs f/u
5. Depressive disorder, not elsewhere classified - 311, stable on celexa
6. Localized superficial swelling, mass, or lump - 782.2, no longer painful no fx on MRI in past no intervention
7. Need for prophylactic vaccination and inoculation, Influenza - V04.81

Treatment
1. Mild cognitive impairment, so stated
   Continue Namenda Tablet, 10 MG, 1 tablet, Orally, Twice a day

2. Abnormality of gait
   referred back to indicated may be at max visits for this year but they are willing to pay out of pocket.

3. Macular degeneration (senile) of retina, unspecified
   will call optho today - explained concerns.

4. Depressive disorder, not elsewhere classified
   Continue Celexa Tablet, 20 MG, 1.5 tablet, Orally, Once a day
discussed option of tapering celexa with daughter we agree that patient has done so much better with no ADR that will continue.

5. Others
   Continue Cranberry Capsule, 250 MG, as directed, Orally
   Continue Calcium 500/D Tablet Chewable, 500-400 MG-UNIT, as directed, Orally
   Continue Alphagan P Solution, 1 drop into affected eye, Ophthalmic, Three times a day
   Continue Lumigan Solution, 0.03 %, 1 drop into affected eye every evening, Ophthalmic, Once a day
   Continue Cosopt Solution, 2-0.5 %, 1 drop into affected eye, Ophthalmic, Twice a day

HPI: family notes poor exercise tolerance, 1-2 blocks...
Case #2: Senior Health

- Presenting Problems: Many points, **High**
  - Cog impairment, depression, weight loss; hip lump-stable 4 points
  - Gait- worsening 2 points
  - Mac degeneration: new, with referral- 4 points
- Data: Hx from family 2pt; lab reviewed 1 pt; immunization 1 pt : **High**
- Risk: prescription drug; new problem; uncertain prognosis (Mac degeneration): **Moderate**
## Case #2: Senior Health

Overall MDM: **HIGH**
Pearls for documenting MDM

• Diagnosis
  – 1 new problem without w/u = level 4 dx
  – 1 new problem with w/u = level 5 dx

• Risk: Moderate Risk=level 4 visit
  – Prescription drugs
  – 1 chronic illness w/ progression or SE of tx
  – 2+ stable illnesses
  – undiagnosed new problem
Pearls for documenting MDM

• Data
  – 7 labs count the same as 1 lab (1 point)
  – Document if you discuss test with performing MD (1 pt)
  – Document when you personally view and interpret a test (2 pts)
    • EKG, x-rays, Urine dip, rapid strep
  – Document/summarize history from others (2 pts)
  – Document data from old records (2 pts)
    • “old records reviewed” is NOT adequate
Medical Decision Making

QUESTIONS?
Elements for E&M visits

• History
  – CC
  – HPI bullets (8)
    • Location
    • Quality
    • Severity
    • Duration

• Timing
• Context
• Modifying Factors
• Associated signs and symptoms
For Acute or Chronic Patient

• **Duration**
  – Years/months/days/hours

• **Severity**
  – 6/10 pain; BP 190/110; sugars over 250 at home/4 pads/hour bleeding/Hgb 5.1/needs nebs Q2 hrs

• **Modifying Factors**
  – PT treatments; medications taking; position changes; a good cry...

• **Associated Symptoms**
  – Anything you ask!
1997 revisited

- 1997 guidelines: An *extended* HPI consists of at least four elements of the HPI or the *status of at least three chronic or inactive conditions*
- For level 4 of 5 return visit, can document, “pt here to f/u HTN, DM, and rash” *works for 1995 and 1997 guidelines as of September 2013*
- 4 HPI elements is most needed

- For remaining elements of HPI:
  - Detailed 2ROS 1 PFSH
  - Comprehensive: 10 ROS 2 PFSH
Elements for E&M visits

- History
  - CC
  - HPI
  - ROS (14)
    - Constitutional-fever/wt
    - Eyes
    - Ears/nose/mouth/throat
    - CV
    - Respiratory
  - GI
  - GU

- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Endocrine
- Heme/lymphatic
- Allergic/Immunologic
Elements for E&M visits

• History
  – CC
  – HPI
  – ROS
  – PFSH
  • Past Medical History
  • Family history
  • Social history
Pearls for History

• Can refer to previously documented elements: “problem list updated as part of today’s visit”
• “Complete ROS o/w negative”
• Taking history from someone other than the pt can increase level of MDM
• Single bullets satisfy PFSH requirements—does not need to be exhaustive...

• **BUT don’t forget about patient care**
Elements for E&M visits

- Exam
  - # of organ systems (12)
    - Constitutional-VS, general appearance
    - Eyes
    - Ears, nose, mouth, throat
    - CV (edema, pulses)
    - Respiratory
    - GI

- GU
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Heme/lymph/immunologic

Extremities? Edema? Neck? Thyroid?
Elements for E&M visits

- Exam
  - # body parts (10)
    1. Head (includes face)
    2. Neck
    3. Chest (includes breasts and axilla)
    4. Abdomen
    5. Genitalia, groin, buttock
    6. Back (including spine)
    7-10. Each extremity
Physical Exam

• How many PE elements can you document before examining the patient?
• At least 7
  – General appearance
  – Eyes- sclera anicteric/injected
  – HENT- hearing intact (hard of hearing)
  – MSK- normal gait/limping
  – Psych-normal (depressed/flat) affect
  – Skin-no rash on face, arms
  – Immunologic-NKDA (use for PMH or PE)
95 versus 97

- Physical exam is the difference
- 1995
  - Organ systems
  - Body part
  - Loosy goosy
- 1997
  - General
  - Various specialty exams
  - Proscriptive
# 97 exam example: Respiratory

<table>
<thead>
<tr>
<th>System/Body Area</th>
<th>Elements of Examination</th>
</tr>
</thead>
</table>
| Constitutional   | • Measurement of any three of the following seven vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff)  
• General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming) |
| Head and Face     |                         |
| Eyes             | • Inspection of nasal mucosa, septum and turbinates  
• Inspection of teeth and gums  
• Examination of oropharynx (eg, oral mucosa, hard and soft palates, tongue, tonsil and posterior pharynx) |
| Ears, Nose, Mouth and Throat | • Examination of neck (eg, masses, overall appearance, symmetry, tracheal position, crepitus)  
• Examination of thyroid (eg, enlargement, tenderness, mass)  
• Examination of jugular veins (eg, distention, a. v. or cannon a waves) |
| Respiratory      | • Inspection of chest with notation of symmetry and expansion  
• Assessment of respiratory effort (eg, intercostal retractions, use of accessory muscles, diaphragmatic movement)  
• Percussion of chest (eg, dulness, flatness, hyperresonance)  
• Palpation of chest (eg, tactile fremitus)  
• Auscultation of lungs (eg, breath sounds, adventitious sounds, rales) |
| Cardiovascular   | • Auscultation of heart including sounds, abnormal sounds and murmurs  
• Examination of peripheral vascular system by observation (eg, swelling, varicosities) and palpation (eg, pulses, temperature, edema, tenderness) |
| Chest (Breasts)  |                         |

## System/Body Area

<table>
<thead>
<tr>
<th>Elements of Examination</th>
</tr>
</thead>
</table>
| Gastrointestinal (Abdomen) | • Examination of abdomen with notation of presence of masses or tenderness  
• Examination of liver and spleen |
| Gynecological          |                         |
| Lymphatic              | • Palpation of lymph nodes in neck, axillae, groin and/or other location |
| Musculoskeletal        | • Assessment of muscle strength and tone (eg, flexion, cog wheel, spastic) with notation of any atrophy and abnormal movements  
• Examination of gait and station |
| Extremities            | • Inspection and palpation of digits and nails (eg, chapping, cyanosis, inflammation, petechiae, hemorrhages, nodes) |
| Skin                   | • Inspection and/or palpation of skin and subcutaneous tissue (eg, rash, lesions, ulcers) |
| Neurological/Psychiatric | Brief assessment of mental status including  
• Orientation to time, place and person  
• Mood and affect (eg, depression, anxiety, agitation) |

**Problem Foc:** 1-5 bullets  
**Exp Prob Focused:** 6+ bullets  
**Detailed:** 12+ bullets  
**Comprehensive:** perform all bullets; DOCUMENT every element in shaded box AND 1+ element in other boxes
1997 PE guidelines (Gen)

- Problem Focused: 1\(^{-5}\) bullets in 1 or more systems (99201/99212)
- Expanded Problem Focused: 6\(^{-11}\) bullets in 1 or more systems (99202/99213)
- Detailed: 12 bullets in 2 or more organ systems or 6 systems w/2 bullets each (99203/99214)
- Comprehensive: 2 bullets from 9 + organ systems (99204/5 and 99215)
Pearls for Documenting Exam

• Notations such as “negative” or “normal” are sufficient to document normal findings related to *unaffected* body areas or asymptomatic organ systems

• HEENT-Normal: only counts as 1 organ system, so:
  – Eyes- sclera anicteric
  – ENMT- OP clear/red/whatever...
Case #1: PM&R

39 yo male, no sig PMH evaluated in ED 1 month ago. He had fallen in the tub and experienced R leg pain. Was seen and given IM injection and Rx for NSAIDs. Pain is improving, x mild(?) flare up about 1 week ago, no back pain. R leg pain involving posterior aspect of thigh, popliteal fossa, not ____________.

HPI: Context (fallen in tub)
Duration (1 month)
Location (right leg)
Alleviating (NSAIDs) 4+
ROS: 1; PMH: meds
EPF (level 2 new)
Case #1 PM&R

- PE: thin male in NAD; A&O X3; ____________
- BUE full ROM; good __; normal strength
- BLE with Nl strength, tight hamstrings, full DF/PR
- Nl sensation, no atrophy; 2+ DTRs; symmetric
- LS spine c Nl ____ lordosis; no paraspinous spasm; _____________ L5 ____________; Nl gait.

- PE: Gen; Psych : MSK; Neuro (Organ systems)
  Detailed (level 3 new)
Case #1 PM&R

- Overall Code?
- History: EPF Level 2 new
- Exam: Detailed Level 3 new
- MDM: Low Level 3 new
- Need 3/3 for new patients, so: 99202
- Physician billed 99205

- Could get 99203 with 1 additional ROS: no leg weakness or numbness; no bowel or bladder incontinence, no fevers.
Case #2
**Case #2: Senior Health**

**History of Present Illness**

**Hip/Thigh:**
- Left hip had a mass had MRI showed gluteal edema. Now not painful walking stable using cane no falls. Family notes it is still there. She does note she is afraid of falling - family notes poor exercise tolerance 1-2 blocks feels unsteady no fall since last visit but inquiring about further PT.

**General:**
- Appetite good eating well.
- Weight loss had lost weight to 103 now back up with good appetite.

**Memory Loss:**
- MCI - stable no further decline.

**Constipation:**
- Resolved with 2 stool softeners at night fruits and vegetables. Not complaining today.

**Blurred Vision:**
- C/o worsening vision in right eye has "macular hole" complaints started 1-2 weeks ago. Had seen week before it began so they did not pursue another appt.

**General HPI:**
- Had good summer - spent 2 weeks in NC with family and celebrated 97th birthday.

**Current Medications**

**Medications**
- PMH
- SH

**Allergies**

**ROS:** 10 documented
Case #2: Senior Health

Examination
General Examination:
GENERAL APPEARANCE: appears stated age, alert, no acute distress, well appearing. LUNGS: clear to auscultation bilaterally. HEART: normal S1S2. ABDOMEN: soft, non-tender, no organomegaly, bowel sounds are normal. EXTREMITIES: no clubbing, cyanosis, or edema. SKIN: no rash, 4 cm lesion right cheek consistent with seborrhiec keratosis - scattered other ones on skin. MUSCULOSKELETAL: left hip with post hard protrusion nontender present before. Gait shuffling short steps unsteady on turn but able to transfer onto exam table well. LAB TESTS REVIEWED: cbc chem from 3/12 acceptable and reviewed.

PE: 7 organ systems
Gen
Pulm
CV
GI
Skin
MSK
Neuro: gait, and “alert”

Extremities?
Clubbing and cyanosis = MSK
Edema = CV
• What level of service has been delivered and documented??
Case #2: Senior Health

- History: Comprehensive
- PE: Detailed
- MDM: High

- Need 2/3: 99215 is billable
- Provider billed 99214
Opportunities?

“it’s the EMR…I don’t have enough time…so many patients each day…”

ALL CODING TALKS, PARAPHRASED
Why should you care?

• Audit scrutiny- NGS: National Govt Services; Jurisdiction K: includes NY
  – Pre-payment audit May-June 2013 GIM 99205
    • >2500 services; error rates exceeded 70%
    • “majority recoded to lower E&M level due to lack of documentation in H; PE; or high comp MDM”
  – Pre-pay audit for 99215 for Oncology (June-August 2013)
    • 2000 services reviewed; error rates >75%
  – 99223 (initial hosp) Gen Surg (June-August 2013)
    • >700 services reviewed; error rates >80%
  – 99233 (subs hosp) Cardiology and Gastroenterology (June-August 2013)
    • >4500 services reviewed; error rates >70%
  – October 2013: All above expanding to all specialties
Preventive Services
Preventative Service Visits

• NO Chief complaint or HPI
• MUST HAVE
  – Comprehensive ROS (10 organ systems)
  – Comprehensive or interval PMH, FH, SH
  – Comp. assessment of RF appropriate to age
  – Multi-system PE appropriate to age and RF
  – Assessment/Plan which includes counseling, anticipatory guidance and RF reduction
Preventative Service Visits

- New vs. Return rules are the same
- Coding based on age of patient
- NO specific guidelines for what to include with each age group
- Documentation of anticipatory guidance/ RF reduction was the common missing element in my group (residents are frequent culprits)
- Can refer to previous ROS, PMH, FH, etc
Preventative Service Visits

- 99381-99384 (ages 0-17) new
- 99385-99387 (ages 18->65) new
- 99391-99394 (ages 0-17) return
- 99395-99497 (ages 18->65) return

- Commercial Ins coverage issues; Medicare non-covered
- 99214/5 for annual preventive visit??
Time Based Coding
Counseling

- When time spent counseling >50% of total visit, then TIME becomes the deciding factor for coding
- Total billing provider (residents don’t count) face to face time
- 99213: 15 min  99214: 25 min  99215: 40 min
- Must document total time, time spent counseling and reason for counseling
Counseling is:
Counseling is:

“a discussion with the pt and/or family concerning one or more of the following areas”  CPT book

- Recommended tests, diagnostic results, impressions
- Prognosis
- Risks/benefits of treatment (management) options
- Instructions for treatment (management) options and follow up
- Importance of compliance with treatment (management) options
- Risk factor reduction
- Patient and family education
The Electronic Health Record

Friend or Foe?*

*Rhetorical question, not a survey....
EMR pitfalls

Image courtesy of Habbick/ FreeDigitalPhotos.net
EMR Pitfalls

• Cut and Paste
• Carry Forward
• Lack of editing
  – Conflicting information (HPI/ROS/PE)
  – Repetitive information from previous visits

• Recommendations:
  – If using templates: make them ADD ON type
  – If EMR pulls in labs/data: review, edit and delete
  – If attesting learner’s notes; READ THEM
• The purpose of the progress note is to provide an accurate depiction of treatment on a specific date of service. It is unnecessary to duplicate by copying and pasting information that does not specifically reflect work done on a single date of service.

• Only those diagnoses that were addressed or directly impact a specific date of service are included in the note.
Take home messages

• Documentation guidelines exist:
  – Document for patient care; it PAYS to think like a coder...
• Document work you already do
• Recognize the base codes for the work that you do (99203-05; 99213-15)
  – Key documentation requirements
• Medical Necessity is the key
  – especially with EMR: beware of note bloat
THANK YOU!!

I did not hit you...
I simply high-fived your face.

CMS

you
Helpful links

- **IPPE**

- **AWV**

- **E/M Documentation**

- **TCM**

- **Medicare preventive services**