Evaluation & Management

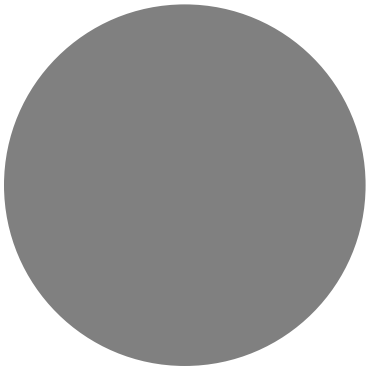
Shannon O. DeConda
CPC, CPC-I, CPMA, CEMC, CEMA, CRTT
President, NAMAS
Partner, DoctorsManagement

Evaluation and Management Components

- We will now look at the each of the components necessary for an accurately reported E/M level of service. The primary components are:
  - History
  - Examination
  - Medical decision making
- Time may be considered as a component, but ONLY when counseling and coordinating of care dominate the encounter.
- Time may NOT be used as a “seat belt”.

Time-based Documentation

- There are times when it is more appropriate to report an E/M encounter based on the amount of time the provider spent with the patient.
- Examples of instances when time may be better suited to the encounter:
  - Visit intended for the review of labs or testing results and care plan options with the patient
  - Test results consume the visit
  - Reviewing risks and benefits of a treatment are discussed
- In order for the documentation to qualify for time-based billing, the documentation should include the total amount of face-to-face time between the provider and the patient along with a few sentences stating what was discussed.



Time-based Documentation

- There is no recommendation that states where this must be noted within the medical record.
- CMS does require, according to 30.6.1C of the Claims Processing Manual that still time alone is not the only consideration in counseling and coordination of care.

  "… The physician may document time spent with the patient in conjunction with the medical decision making involved…"
- CMS expects that the level of service should be selected based on the total time, but also the MDM of the encounter.

Key Component: History

- The history portion of the medical record should include documentation in four distinct areas.
  - Chief complaint should be documented to tell us why the patient is having the current encounter.
  - History of Present Illness (HPI) must be included to explain how the chief complaint is affecting the patient symptomatically.
  - Review of Systems (ROS) is required documentation because it tells how the chief complaint is affecting the patient's body systems.
  - Past, Family, and Social History (PFSH) is important documentation as it tells how the patient's previous history has or will affect the chief complaint.
- Using these elements, the history works together to define the severity of the problem according to the patient.

Chief Complaint

- This is the only true documentation guidelines we have for chief complaint.
- What if the CC was missing?
- What about a CC of "follow up"?

CHIEF COMPLAINT (CC)

The CC is a concise statement describing the symptom, problem, condition, diagnosis, physician recommended return, or other factor that is the reason for the encounter.

- *DG: The medical record should clearly reflect the chief complaint.*

History of Present Illness (HPI)

- The HPI is a description of the development of the patient's present illness from the first sign and/or symptom or it tells changes/developments since the previous encounter(s).
- The HPI expands the documented chief complaint by telling us how the chief complaint has affected the patient symptomatically.
- We have two ways to evaluate the HPI
  - Using a max of 4 of the 8 HPI elements
  - Status of 3 chronic or inactive diseases
  - Negative findings in the HPI more clearly represent the ROS

History of Present Illness (HPI)

8 Elements

- Location— This element documents the location of the patient's problem.
  - An auditor may not use an implied location.
  - How much location is enough location?
  - Neither 95 nor 97 guidelines define location to an extent that would not allow any clearly defined location.
- Quality— This element should communicate within the documentation the standard of the presenting problem as measured to the patient's normal condition.
  - Easily documented for most any condition.
  - Many auditors do not fully understand what quality is supposed to define.

History of Present Illness (HPI) …continued

8 Elements (cont'd)

- Severity—Severity is the degree of compromise that the patient is experiencing due to the presenting problem.
  - Many auditors feel that the pain scale is the only valid method of documenting the severity of the patient.
- Duration—This tells the physician how long the patient has had the presenting problem(s)
  - Durations not associated with the presenting problem should not be considered.
  - Duration is not met when the provider documents how long since their last visit, or 6 month follow up.
  - Some auditors allow "onset" to be used for duration.
- Timing—The physician needs to know when the patient's identified problem is affecting them the most.
  - Timing tells us if the problem is occurring only at night, continuously, intermittently, or any type of repetitive pattern.
  - Oftentimes there is confusion between duration and timing.

History of Present Illness (HPI) …continued

8 Elements (cont'd)

- Context—This identifies such characteristics as where the patient is or what the patient was doing when the first symptoms occurred.
  - Context can also identify what was present before and/or after the problem began.
  - Context that indicates the patient has no known injury can be very significant in treating the patient.
  - It would need to be applicable to the patient's presenting problem.
- Modifying Factors— defines about the patient exactly what it says.
  - Tell what the patient does to try and modify their current condition.
  - This can range from changes in lifestyle, movement, ADLs to what medications or procedures the patient has had to try and alleviate the problem.
  - Tell what makes the problem worse as well.
  - There is an auditor opinion that if the documentation does not indicate if the patient experienced relief or not, that it does not meet the standard for this HPI element.

History of Present Illness (HPI)
…and finally

8 Elements (cont'd)

- Associated Signs & Symptoms—This element of the HPI is sometimes inadvertently bundled into the chief complaint.
  - There are auditing concerns of extracting this information out of the chief complaint and fears of this being a double dipping scenario.
  - HPI elements are most always positive findings of symptomology the patient has related to their presenting problem.
  - Negative findings are supportive of the ROS as they indicate how the patient is NOT being affected.

Status of 3

- The 1997 documentation guidelines give more flexibility in the documentation of the HPI.
  - Allow for the status of three chronic or inactive conditions of the patient.
- CMS has recently advised that the HPI may be documented in this 97 standard and also use a 95 exam during the same encounter.
  - Not all carriers have agreed to this new definition.
  - CMS has not updated their own E/M Services Guide to reflect this change.
- How much "status" of the problem should be included?
- At minimum the documentation should identify the problem is stable or not.

History: Review of Systems (ROS)

- Whether documenting with the 1995 or the 1997 documentation guidelines, the ROS rules are consistent.
- The ROS documentation should be an accounting of how the patient's organ systems are being affected by the presenting problem.
- Must be documented as either a negative or positive responses.
- We must be able to count how many organ systems were reviewed.
- Words such as unremarkable and noncontributory are not acceptable forms of ROS documentation.
- It is not necessary for a physician to tell us within the ROS what the specific negative findings are; however, the documentation should list the specific pertinent positive findings.
- The ROS would include documentation of each organ system, but the key is being able to analyze the findings for accurate system accounting.

Review of Systems (ROS)

- A very effective way to document the ROS is by using a braod "all other systems are negative."
- Some providers do have concern regarding legal implications, so we recommend a slight variation of "all other systems are negative as they relate to the chief compliant"
- This is substantiated within 1995 and 1997 documentation guidelines.
- There are 2 keys to documenting in this way:
  1. We must be able to clearly identify the other organ systems as normal or negative.
  2. We must be able to make note the number of organ system by the wording.
- Why is this effective?
  - Reduces the risk of contradictions
  - Reduces the appearance of "cloning" or inappropriate template usage
  - If the patient's body is truly not be affected by the chief complain in any other area, it is the most effective word choice to convey this
- According to guidelines, the "work" of the ROS may be the work of ancillary staff, or even work of the patient.

Review of Systems

- You cannot double dip
- Double dipping refers to using one symptom for scoring in 2 different components such as the HPI and the ROS
- No MAC indicates they allow double dipping

Carrier	Guidance: Must an encounter ALWAYS include documentation in ALL 3 key components
WPS Medicare	No additional guidance
Noridian	The same documentation/entry in the notes may not be counted in two areas. The same statement cannot be used as an example for HPI and ROS, just one or the other. The HPI as a reminder is reviewing elements related to the chief complaint.
Novitas	ROS inquiries are questions concerning the system(s) directly related to the problem(s) identified in the HPI. Therefore, it is not considered "double dipping" **to use the system**(s) addressed in the HPI for ROS credit.
Cahaba	No additional guidance
First Coast	The same element would only be counted once. In the example given, there are two different elements indicated (shortness of breath and chest pain), so this would count for both HPI and ROS, respectively.
Palmetto	Documentation cannot be used twice under the History Component. This is referred to as 'double dipping.' Example: Allergies may be used under the ROS (Allergic/Immunologic) or under past history.
NGS	No additional guidance
CGS	No additional guidance

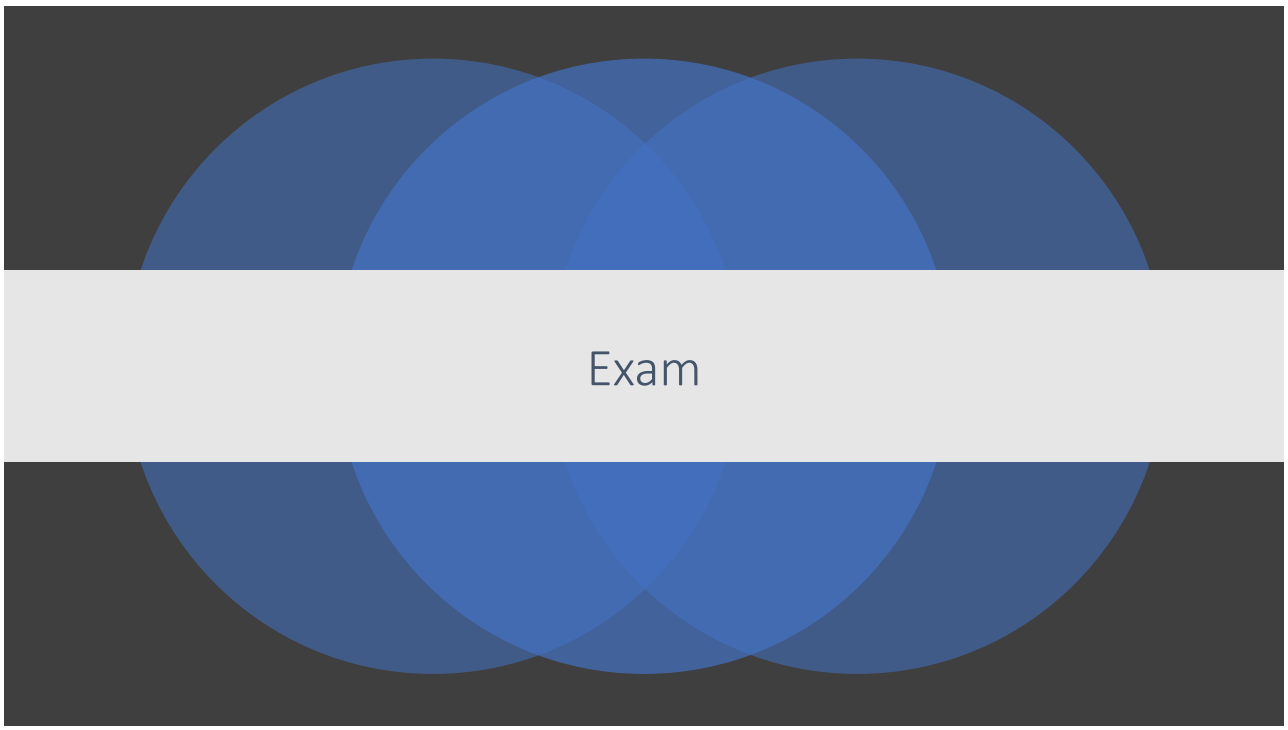
Past Family Social History (PFSH)

Within the 3 areas of PFSH, the following defines examples of what would be expected documentation within these areas.

- **Past History**—The documentation of the past history should tell us information pertinent to the patient's past that may have an impact on the current treatment of the patient.
  - Immunization status
  - Current medications
  - Past surgeries
  - Past illnesses/injuries
  - Prior hospitalizations
  - Prior operations
  - Age appropriate feeding/dietary status
  - Allergies (e.g. drug, food)
- **Family History**—This history information should tell us any problems that have been relevant to the patient's immediate family that may have a bearing on the chief complaint and the plan of care. CPT indicates:
  - Health status or cause of death of parents, siblings, and children
  - Hereditary diseases or diseases of the family that put the patient at risk
- **Social History**—This documentation should include information regarding the social interactions the patient may have that will affect the regimen of care.
  - Smoking
  - Alcohol intake
  - Marital status or living condition
  - Sexual history
  - Educational information
  - Military history
  - Drug use
  - Other relevant social factors
  - Employment status

Scoring the Overall History of the Encounter

- The area scoring the lowest level defines the overall level of history.
- We do NOT drop the lowest area documented.
- The easiest way to remember how to use the audit grid in this area is "*to the left, to the left*"



Exam

- Significant difference between 1995 and 1997 Documentation Guidelines.
  - 1995 Documentation Guidelines are more general in nature and allow a broader form of documentation of the findings.
  - 1997 Documentation Guidelines are specialty specific and therefore the findings of the exam are much more specific
- The exam is the objective portion of the documentation.
- Seeks to find how the patient is externally of the perceptions, thoughts, or feelings.

Exam

- Exam documentation must be specific to that date of service.
- Provider cannot refer to a previously performed/documented exam.
- Nor could the provider refer to an exam performed by another provider.
- Documented to demonstrate the findings are either negative/normal or what the pertinent positive problems of the exam are.

Exam

- Templated exams a common form of documentation.
- Organ system with a "laundry list" of findings noted for each.
- Template documentation is allowed according to Medicare.
- Advise providers that if the documentation indicates those organ systems as being examined, then it would be expected that the patient could confer they were examined.

1995 Documentation Guidelines

- 1995 does specifically identify the body areas within the guidelines and it does indicate their inclusion.
- An auditor must be sure they have an understanding of the limited use allowed of the body areas.
- In the guidelines all levels of exam are noted as including the following statement:
  - *An [ ] examination of the affected body area or organ system…*
- Since 1995 exam guidelines focus on the full organ system examined, there are no specific finding necessary other than that of negative/normal or the pertinent positive findings of the exam.
- It would be inappropriate for the provider to document that an organ system is abnormal and not identify what about that organ system is abnormal.

1995 Documentation Guidelines

Level	Findings
PF Exam	1 organ system: the exam should include the site of the presenting problem
EPF Exam	2 organ systems: the exam would include the sit of the presenting problem along with another organ system
D Exam	2 organ systems: the exam would include an exam that we can considered an extended exam of the site of the presenting problem along with another organ system
C Exam	8 or more organ systems or a complete exam of the affected organ system

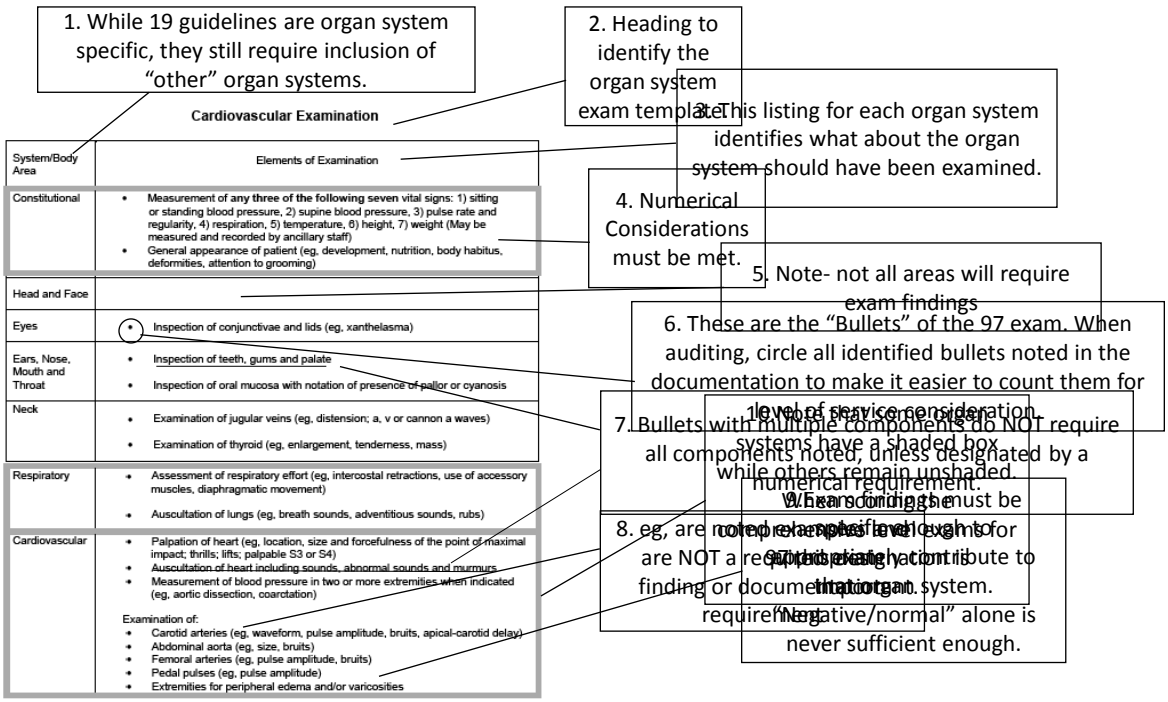
Detailed Exam Discrepancies

Carrier	Guidance: Carrier Discrepancies over "Detailed" Exam
WPS Medicare	Same guidance as 1995 Documentation Guidelines
Noridian	Same guidance as 1995 Documentation Guidelines
Novitas	Our reviewers utilize one of the following when making a determination on whether an examination is expanded problem focused or detailed. The method chosen must be the one that is most beneficial to the physician. o 1997 E&M examination guidelines, o 1995 E&M examination guidelines utilizing the 4 x 4 tool, or o 1995 E&M examination guidelines utilizing clinical inference
Cahaba	Detailed Exam is Defined as: It may be either an examination of at least five organ systems/body areas (according to the 1995 version of the documentation guidelines) or the performance and documentation of at least 12 specific exam findings (according to the 1997 version). This would indicate same guidance as 1995 Documentation Guidelines of at least 2 organ systems with one in detail.
First Coast	Same guidance as 1995 Documentation Guidelines
Palmetto	The 1995 body systems detailed exam requires documentation of two through seven body systems with more detail. The 1995 body areas detailed exam requires documentation of two through seven body areas with more detail. 'More detail' refers to the extent of the exam. The level of detail involved in an exam is a clinical judgment based on the documentation for each individual medical record. There is an expectation that the exam will be more involved, and therefore more documentation would be submitted for a detailed exam. The documentation for a detailed exam would consist of at least two findings for at least two body areas or two organ systems.
NGS	Detailed (level 4): 6-7 organ systems or body areas.
CGS	Same guidance as 1995 Documentation Guidelines

1997 Documentation Guidelines

- Examinations focus on specific body systems and the findings must be specific instead of broad general statements like “normal.”
- In 1997 an organ system exam is weighted on the complexity by volume documented.
- 1997 exam guide applies a “bullet” methodology
- The 1997 Exam Guide offers 2 forms of exam styles.
- The less common one used is the General Multisystem Exam.
- The more commonly used 97 exams are the organ specific exams, which include exam templates for the following organ systems:

  - Cardiovascular
  - Ears, nose, mouth, and throat
  - Eyes
  - Genitourinary of female
  - Genitourinary of male
  - Hematologic/Lymphatic/Immunologic
  - Musculoskeletal
  - Neurological
  - Psychiatric
  - Respiratory
  - Skin



Specialty Specific Exam

1. The exam level is chosen based on the number of bullets noted in the exam

5. Exam MUST include:
- All bullets on the exam template
- In shaded boxes every element must be noted
- In unshaded boxes- only one element must be noted.

Content and Documentation Requirements	
Level of Exam	Preform and Document:
Problem focused 99201-99212	**One to five** elements identified by a bullet.
Expanded Problem Focused 99202/99213	**At least six** elements identified by a bullet.
Detailed 99203/99214	**At least twelve** elements identified by a bullet.
Comprehensive 99204/99205/99215	Perform **all** elements identified by a bullet; document every element in each box with a shaded border and at least one element in each box with an unshaded border.

2. Minimum of one bullet

3. Minimum of six bullets

4. Minimum of twelve bullets

General Multi-System Exam

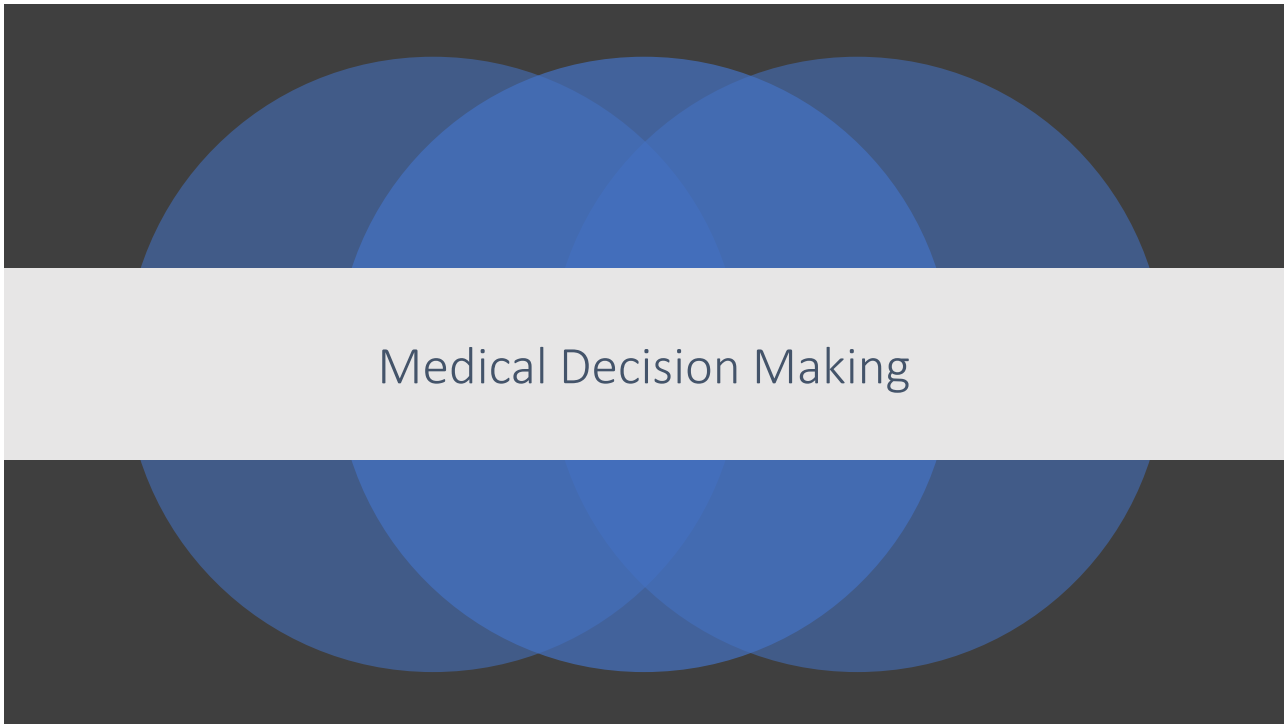
Content and Documentation Requirements	
Level of Exam	<u>Preform and Document:</u>
Problem focused 99201-99212	**One to five** elements identified by a bullet.
Expanded Problem Focused 99202/99213	**At least six** elements identified by a bullet.
Detailed 99203/99214	**At least two** elements identified by a **bullet from each of six areas/systems** OR at least twelve elements identified by a bullet in two or more areas/systems.
Comprehensive 99204/99205/99215	Perform **all elements** identified by a bullet **in at least nine** organ systems or body areas and document **at least two** elements identified by a bullet **from each of nine areas/systems.**

1. Minimum of one bullet

2. Minimum of six bullets

3. Minimum of twelve bullets, but must satisfy either:
1) 2 bullets from 6 boxes
2) 12 bullets but must be at least 2 organ systems

4. A minimum of 9 organ systems and MUST include:
- All bullets in that box
- A minimum of 2 elements in each bullet is required



Medical Decision Making

- The medical decision making (MDM) section of the encounter standardly houses.
  - The diagnoses formally assigned to the patient
  - May include lab/x-ray/test findings
  - The plan of care for the patient's condition(s)
  - Include an assessment of the overall complexity of the patient.
- The MDM includes:
  - The diagnosis section
  - The data and complexity of orders and information reviewed by the provider
  - The table of risk
- We are able to drop the lowest area documented.
- Typically, we find that the data and complexity of orders and information reviewed by the provider.

Diagnosis Section

- The diagnosis section causes confusion for many providers.
- Be sure that diagnoses counted are those that are relevant to the encounter that is being audited.
- Consider the following example:
  - Eric presents to the clinic today with sore throat, diarrhea, and fever. In the MDM of the
    - Encounter the provider notes the following diagnoses:
    - Pharyngitis
    - Diarrhea
    - OA of the Right Knee
    - GERD

Diagnosis Section

- Each diagnosis should now be categorized for appropriate point value.
- The categories to consider are:
  - New problem to the provider
  - Established problem to the provider
  - Self-limited problem

Diagnosis Section

- New problem to the provider:
- Documentation guidelines actually refer to this category as a presenting problem without an established diagnosis
- According to Documentation Guidelines:
  - *For a presenting problem with an established diagnosis the record should reflect whether the problem is: a) improved, well controlled, resolving or resolved; or, b) inadequately controlled, worsening, or failing to change as expected.*
  - *For a presenting problem without an established diagnosis, the assessment or clinical impression may be stated in the form of a differential diagnoses or as "possible", "probable", or "rule out" (R/O) diagnoses.*

Diagnosis Section

- Presenting problems without an established diagnosis are further categorized into two different categories:
  - New problems with additional workup and
  - New problems without additional workup.
- Additional workup is considered work that must be performed beyond the office visit in order to further treat and/or diagnosis the patient's problem.

Carrier Discrepancies: Additional Workup

Carrier	Carrier Discrepancy: Additional Workup
Cahaba	No additional guidance
CGS	No additional guidance
First Coast	No additional guidance
NGS	Additional workup includes all requests by the provider to obtain further diagnostic information to help establish a final diagnosis and plan of care. This includes orders for diagnostic tests and requests for consultative input from other specialty providers.
Noridian	Additional workup is anything done beyond that encounter at that time. For example, if a physician sees a patient in his office and needs to send that patient on for further testing, that would be additional workup. The physician needs to obtain more information for his medical decision-making.
Novitas	Additional workup is anything done beyond that encounter at that time. For example, if a physician sees a patient in his office and needs to send that patient on for further testing, that would be additional workup. The physician needs to obtain more information for his medical decision-making.
Palmetto	Additional Work-up' consists of any diagnostic testing, laboratory testing, etc. and may be performed at the time of the visit.
WPS Medicare	No additional guidance

Diagnosis Section

- Established problem to the provider:
- Scored based on whether the current diagnosis is improving, stable, or worsening, inadequately controlled or failing to change as expected.
- This is the information that many providers fail to adequately document in their note to appropriately define the complexity of care.
- 1995 and 1997 Documentation Guidelines expressly state within the MDM that the provider is permitted to have an “implied” state of the patient’s condition
- *For each encounter, an assessment, clinical impression, or diagnosis should be documented.* ***It may be explicitly stated or implied*** *in documented decisions regarding management plans and/or further evaluation.*

Diagnosis Section

Status	# of points	Example
Stable	1 per diagnosis	No changes made to current management of the patient
Improving	1 per diagnosis	Medications, therapies, or restrictions are discharged from the patient
Worsening	2 points per diagnosis	New testing, medications, consults, or procedures are performed/ordered for the patient

Data and Complexity

- This section equates point value to the provider for services provided to the patient during the encounter.
- The points in this area are then combined for a total which then converts to a specific level of service.
- The maximum number of points needed in this section is 4.

Data and Complexity

- Points vary and are assigned for:
  - 1 Point: Documentation supporting that the provider reviewed testing results of a patient with the provider who performed the test.
  - 1 Point: Documentation identifying that the provider requested records from another facility or provider for the patient.
  - 1 Point: Documentation would need to indicate that additional history was received from a source other than the patient. The information received from the source would be additional history information that would supplement that of the patient's noted history. This component is not for instances when the entire history his obtained by someone other than the patient. Much confusion exists in this point as it relates to pediatrics. Supplementing the history information of a minor child from a guardian would be a normal course of the E&M encounter in the pediatric office and not eligible.

Data and Complexity

  - 2 Points: Documentation that indicates that the entire history of the patient had to be obtained by a source other than the patient.
  - 2 Points: Documentation indicating that the old records were obtained for the patient and brief overview of the findings of the records.
  - 2 Points: Documentation that the provider discussed the case with another health care provider. There is no rule as to how long this conversation must last, nor whom is defined as a healthcare provider within this component. Documentation Guidelines reference this only as The results of discussion of laboratory, radiology, or other diagnostic test with the physician who performed or interpreted the study should be documented.
  - 2 Points: When the documentation indicates that the provider performed direct visualization of an image, tracing, or specimen of a test that was previously interpreted by another provider, thereby delivering a unique independent interpretation then 2 points may be credited.
- The total points are added together and this total helps to demonstrate the level of service for this portion of the MDM.

Table of Risk

- Evaluating the patient's overall complexity through a risk scoring level.
- The Table of Risk (TOR) has three categories represented through vertical columns on the table.
  - Presenting problem
  - Diagnostic procedure(s) ordered
  - Management options
- Do not score all three of these categories.
- Chose the element in the entire table that supports the highest or most complex level of risk for the patient encounter.
- When first approaching the TOR it works well to begin with the Management Options in the far right column.

Using the TOR

Use the risk table below as a guide to assign risk factors. It is understood that the table below does not contain all specific instances of medical care: the table is intended to be used as a guide. Select the check boxes of the most appropriate factor(s) in each category. The overall measure of risk is based on the highest level present.

Risk of Complications and/or Morbidity or Mortality			
Level of Risk	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options
Minimal	☐ *One self-limited or minor problem*, e.g., cold, insect bite, Tinea Corporis	☐ Lab 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 non-insulin 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 ☐ Non-cardiovascular 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
Moderate	☐ *One or more chronic illnesses 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 systematic symptoms*, e.g., pyelonephritis, pneumonitis, colitis. ☐ *Acute complicated injury*, e.g., head injury with brief loss of consciousness	☐ Physiologic tests not under stress, e.g., cardiac stress test, fetal contraction stress test ☐ Diagnostic endoscopies with no identified factors ☐ Deep needle or incisional biopsy ☐ Cardiovascular imaging studies with contrast and no identified risk factors, e.g. arteriogram cardiac cath ☐ Obtain fluid from body cavity, e.g., lumbar puncture, thoracentesis, culdocentisis	☐ Minor surgery with identified risk factors ☐ Major surgery (open, percutaneous or endoscopic) with no identified risk factors ☐ Prescription drug management ☐ 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	☐ Major surgery (open, percutaneous or endoscopic with identified risk factors). ☐ Emergency major surgery (open, percutaneous or endoscopic) ☐ Parenteral controlled substances ☐ Drug therapy requiring intensive monitoring for toxicity ☐ Decision not to resuscitate or de-escalate care because of poor prognosis

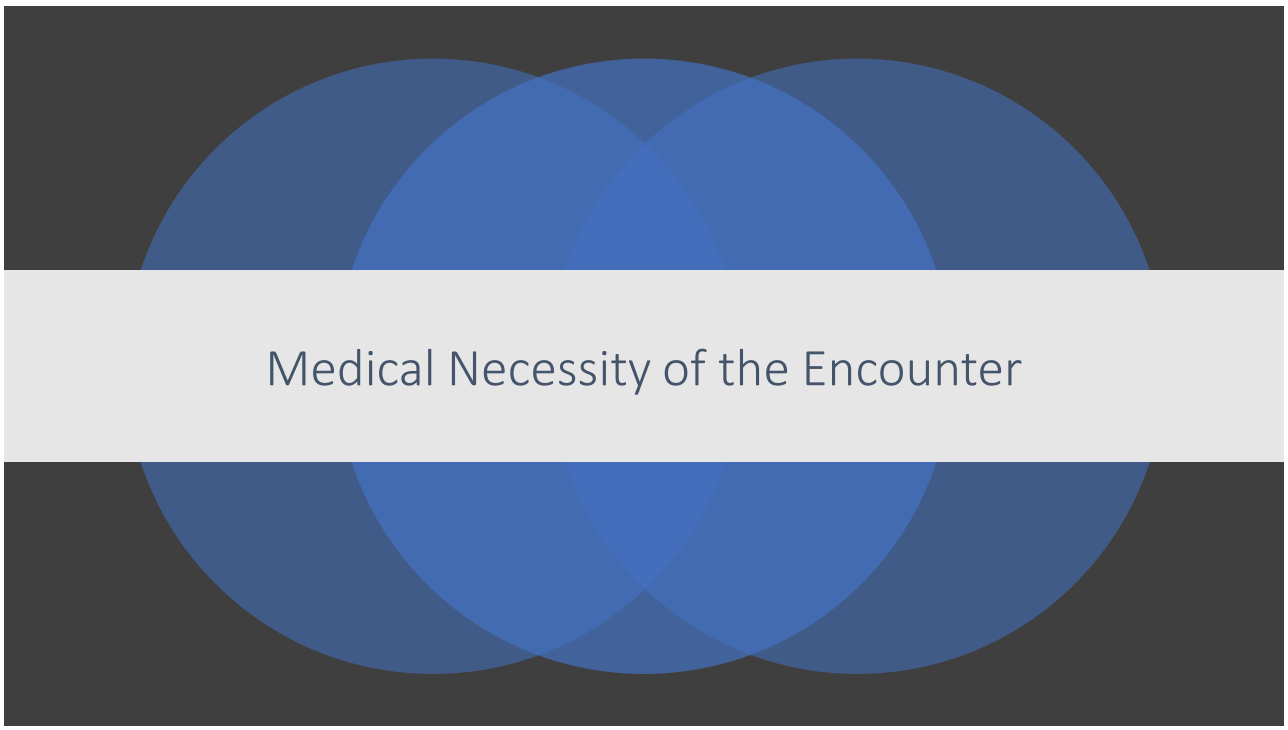
Scoring the Medical Decision Making

- Within the medical decision making, one of the three areas we discussed can be omitted in the scoring process
- We would access all three categories of the MDM, and drop the one that represents the lowest level of complexity
- Example:

  Impression: Diabetes

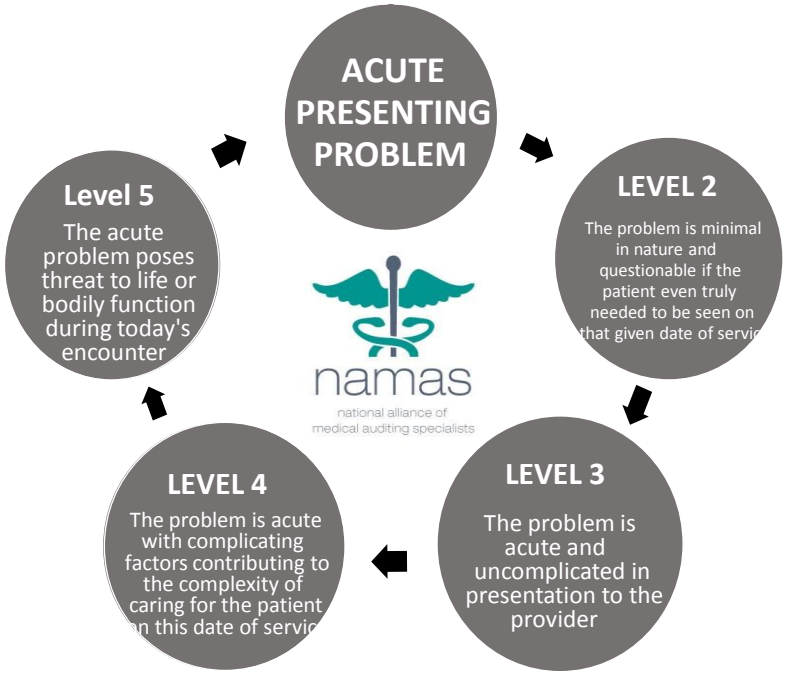
  This is an established patient who has had diabetes for 12 years and over the past month it is fluctuating and not as well controlled. I have requested that he take his sugars three times daily and keep a log, along with monitoring diet, and exercise and return next week for us to evaluate his overall well-being were his sugars are concerned. He would prefer to NOT make any changes to his medications if there is another contributing factor.

Diagnosis	1 or less	2	3	4 or more
Complexity	1 or less	2	3	4 or more
Risk	Minimal	Low	Moderate	High
Level	**Straightforward** 99201/99202/99212	**Low** 99203/99213	**Moderate** 99204/99214	**High** 99205/99215



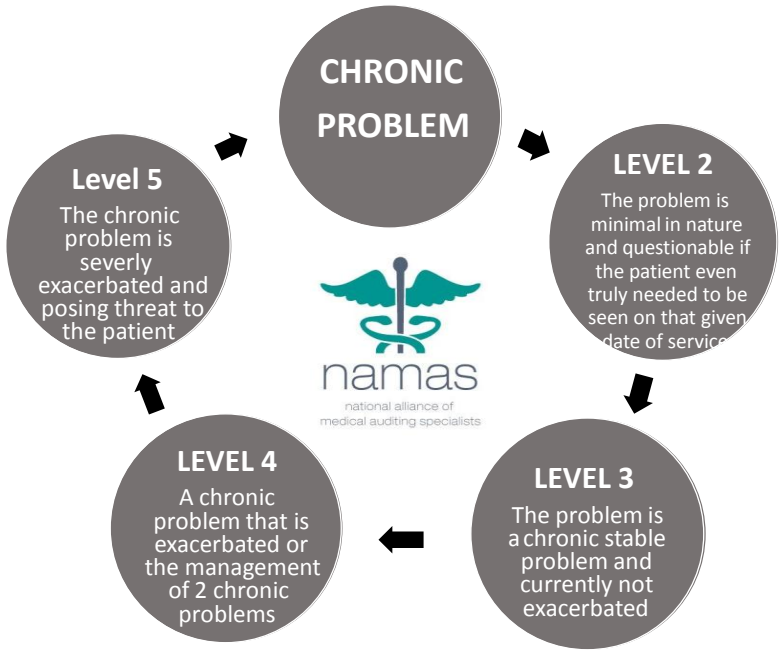
Acute Problems: Office Setting

New or Established Patients



Chronic Problems: Office Setting

New or Established Patients



Patient Encounter to be audited:
Sally Ridersmchidten

Review the CPT/ICD-9 coding on the sample claim form.
Audit the encounter, and answer the questions below.

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)
1. 381.00
2. 465.9
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $CHARGE	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
05 06 13	05 06 13	11		99214		1,2	165	1		NPI	123456789
										NPI	
										NPI	
										NPI	
										NPI	
										NPI	

Atlantic Coast Multispecialty Group

626 NAMAS Avenue
Beachville, FL 32955
321-987-6543

Harriet Oz, M.D. Gregory Peck, M.D. Sadie Piat, M.D. Andrew Wall, M.D.

Does this statement support a level of severity or quality of the pain?

Should we count this as a modifying factor or are we assuming?

Patient: *Sally Ridersmchidten*
Gender: F, DOB: 4/01/2009
Examiner: Harriet Oz, M D
Encounter Date and Time: 5/06/2013 10: Location

Chief complaint
The Chief Complaint is: Mother brought PT in today due to PT waking up screaming and crying with Left ear pain.
Mother has not noticed a fever this morning

Not HPI – count as ROS

Current medication
Children's Mucinex Cough 5-100 *mg*/5 mL Liqd 3.5 mL by Oral route every 4 hours.
Cheratussin AC 10-100 *mg*/5 mL Liqd 2.5 mL by Oral route every 4 hours for cough or congestion.

Associated Sign/Symptom? Or part of the directions from the medication?

Medical: No previous hospitalizations.
Surgical/Procedural: No prior surgery
Exposure: No exposure to tuberculosis.
Environmental Exposure: No exposure to lead.

Past Medical History

Personal history
Behavioral: Never a smoker and never a smoker.
Home Environment: Brother(s) residing in household, 1 sister(s) residing in household, and living with a single parent.
No secondhand tobacco smoke in home. Housing has a well.
Marital: Single.
Family history no significant family history.

Social History

Family History- Not Valid

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Harriet Oz, M.D. Gregory Peck, M.D. Sadie Piat, M.D. Andrew Wall, M.D.

Patient: Sally Ridersmchidten
Gender: F, *DOB:* 4/01/2009 *Encounter Date and Time:* 5/06/2013 10:46AM
Examiner: Harriet Oz, M D
Chief complaint
The Chief Complaint is: Mother brought PT in today due to PT waking up screaming and crying with Left ear pain.
Mother has not noticed a fever this morning.

Current medication
Children's Mucinex Cough 5-100 *mg*/5 mL Liqd 3.5 mL by Oral route every 4 hours.
Cheratussin AC 10-100 *mg*/5 mL Liqd 2.5 mL by Oral route every 4 hours for cough or congestion.

Medical: No previous hospitalizations.
Surgical/Procedural: No prior surgery.
Exposure: No exposure to tuberculosis.
Environmental Exposure: No exposure to lead.

Personal history
Behavioral: Never a smoker and never a smoker.
Home Environment: Brother(s) residing in household, 1 sister(s) residing in household, and living with a single parent.
No secondhand tobacco smoke in home. Housing has a well.
Marital: Single.
Family history no significant family history.

Vitals: Temp: 99.2 Weight: 31 lbs Height: 39.5 in

New Office ○ Established Office ◉
New Hospital ○ Subsequent Hospital ○
Consult ○

E/M Documentation Auditor's Instructions

Reviewer: Shannon DeCond Date of Review: 03/07/2016
Doctor: Harriett Oz, MD Date of Service 05/06/2013 ID#: Ridersmchidten

1. History

Refer to data section (table below) in order to quantify. After referring to data, circle the entry farthest to the RIGHT in the table that best describes the HPI, ROS and PFSH. If one column contains three circles, draw a line down that column to the bottom row to identify the type of history. If no column contains three circles, the column containing a circle farthest to the LEFT identifies the type of history. After completing this table that classifies the history, circle the type of history within the appropriate grid in section 5.

HPI (History of Present Illness): Characterize HPI by considering **EITHER** the status of 3 chronic or inactive conditions **OR** the number of elements recorded.				○ Status of 3 Chronic Conditions
☑Location ☐Severity ☐Timing ☐Associated Signs & Symptoms ☑Quality ☐Duration ☐Context ☐Modifying Factors		◉ Brief (1-3)		○ Extended (4 or More)
ROS (Review of Systems): ☑Constitutional ☐All/Immuno ☐Ears, nose, mouth, throat ☐Integumentary ☐Eyes ☐Musculo ☐Neuro ☐Hem/lymph ☐Cardiac/ vasc. ☐GU ☐Resp ☐GI ☐Psych ☐Endo ☐All other systems were negative	○ N/A	◉ Pertinent to problem (1 system)	○ Extended (pert & others) (2-9 systems)	○ Complete (pert & all others) (10 systems)
PFSH (Past, Family, Social History): ☑**Past history** (the patient's past experiences with illnesses, operations, injuries and treatments) ☐**Family history** (a review of medical events in the patient's family, including diseases that may be hereditary or place the patient at risk) ☑**Social history** (an age appropriate review of past and current activities)	○ N/A	○ N/A	○ Pertinent 1 history item	◉ Complete 2-3 history areas
* Complete PFSH **2 history areas:** a) established patients - office (outpatient) care, domiciliary care, home care; b) emergency department; c) subsequent nursing facility care; and d) subsequent hospital care. **3 history areas:** a) new patients - office (outpatient) care, domiciliary care, home care; b) consultations; c) initial hospital care; d) hospital observation; and e) initial nursing facility care.	PROBLEM FOCUSED 99201 99212	E/P PROBLEM FOCUSED 99202 99213	DETAILED 99203 99214	COMPRE-HENSIVE 99204/99205 99215
	Final History requires all 3 components above are met or exceeded			

Let's Review Medical Necessity
along the way…

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Patient: Sally Ridersmchidten
Gender: F, *DOB:* 4/01/2009 *Encounter Date and Time:* 5/06/2013 10:46AM
Examiner: Harriet Oz, M D
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Medical: No previous hospitalizations.
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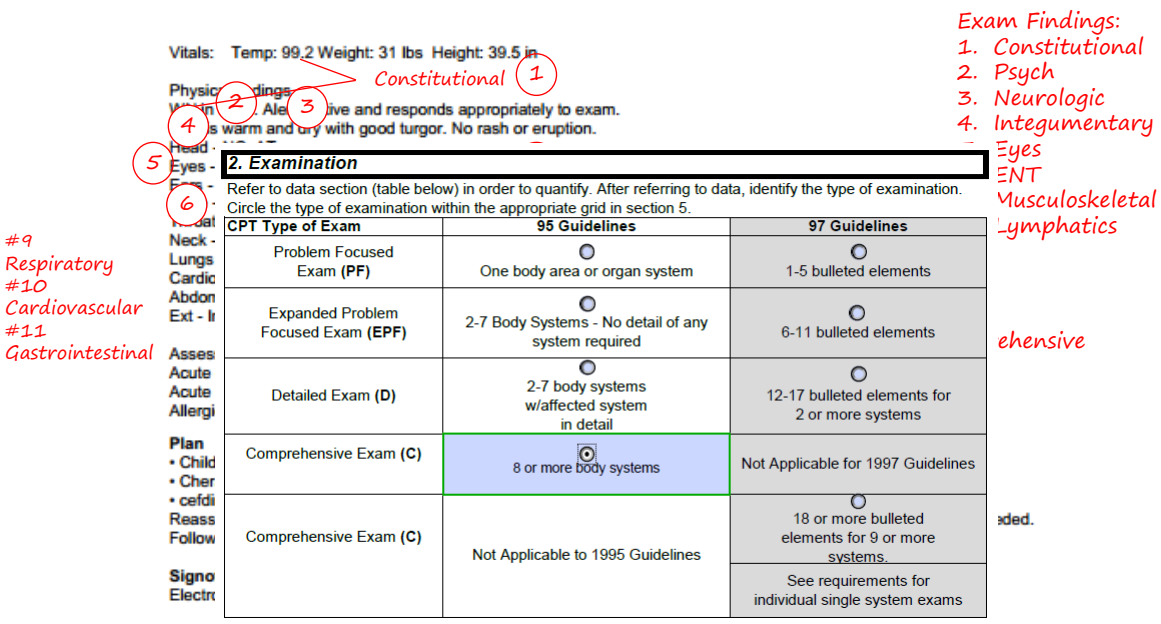
No secondhand tobacco smoke in home. Housing has a well.
Marital: Single.
Family history no significant family history.

Vitals: Temp: 99.2 Weight: 31 lbs Height: 39.5 in

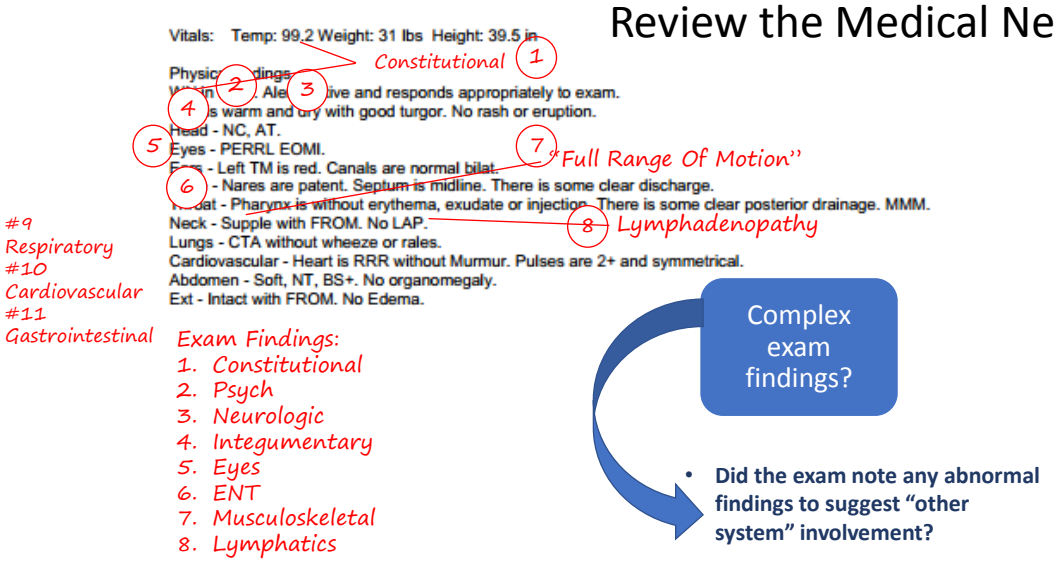
Complexity of care per history?

- When accessing the overall history of the patient, was his chronic problem stable, exacerbated, or severely exacerbated?

Acute Patient
- Level 3- Uncomplicated
- Level 4-Mild Complications
- Level 5- Complications Posing Threat Life/Body Function



Review the Medical Necessity of the Exam



Exam Documentation is Comprehensive
Does the Medical Necessity support the same comprehensive level?

Diagnosis Scoring:

Acute otitis media: New problem to the provider, no additional workup noted

Acute URI: New problem to the provider, no additional workup noted-difficult due to no HPI, clear exam, but do not question the clinical interpretations of a provider unless you can perform peer-to-peer.

Allergies/Reactions: Nothing is documented in the encounter regarding this

Diagnosis Scoring is 6 points, and therefore this area of MDM is at max

Data & Complexity of Review/Orders:
Nothing is documented as being ordered or reviewed

Assessment
Acute otitis media → 3 points for diagnosis
Acute upper respiratory infection → 3 points for diagnosis
Allergies and Adverse Reactions no Known Allergies.

Plan
- Children's Mucinex Cough 5-100 mg/5 mL Liqd 3.5 mL by Oral route every 4 hours.
- Cheratussin AC 10-100 mg/5 mL Liqd 2.5 mL by Oral route every 4 hours for cough or congestion.
- cefdinir 250 mg/5 mL Suspension for Reconstitution. 2.5 mL by Oral route 2 times per day for 10 days.

Reassurance and Age appropriate instruction provided. Mother to Push PO fluids and use Tylenol/Ibuprofen as needed.
Follow Up as needed.

Signoff Information
Electronically Signed By: Harriett Oz, M Don 05/06/2013 at 05:30 PM.

Within the plan the first 2 medications were on the current med list within this history portion of the note. How would you then count these?

Prescription drug management is provided through initiation of an antibiotic
TOR: Moderate Risk

Diagnosis Scoring:
Diagnosis Scoring is 6 points, and therefore this area of MDM is at max

Data & Complexity of Review/Orders:
Nothing is documented as being ordered or reviewed

WN in NAO. Alert, Active and responds appropriately to exam.
Skin is warm and dry with good turgor. No rash or eruption.
Head - NC, AT.
Eyes - PERRL EOMI.
Ears - Left TM is red. Canals are normal bilat.
Nose - Nares are patent. Septum is midline. There is some clear discharge.
Throat - Pharynx is without erythema, exudate or injection. There is some clear posterior drainage. MMM.
Neck - Supple with FROM. No LAP.
Lungs - CTA without wheeze or rales.
Cardiovascular - Heart is RRR without Murmur. Pulses are 2+ and symmetrical.
Abdomen - Soft, NT, BS+. No organomegaly.
Ext - Intact with FROM. No Edema.

Prescription drug management is provided through initiation of an antibiotic
TOR: Moderate Risk

Assessment
Acute otitis media
Acute upper respiratory infection
Allergies and Adverse Reactions no Known Allergies.

Plan
- Children's Mucinex Cough 5-100 mg/5 mL Liqd 3.5 mL by Oral route every 4 hours.
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Reassurance and Age appropriate instruction provided. Mother to Push PO fluids and use Tylenol/Ibuprofen as needed.
Follow Up as needed.

Signoff Information
Electronically Signed By: Hi

Final Result for Complexity					
A	Number of diagnosis or treatment options	Minimal	Limited	Multiple	Extensive
B	Amount and complexity of data	Minimal or low	Limited	Multiple	Extensive
C	Highest risk options	Minimal	Low	Moderate	High
Complexity of decision making		**Straight Forward**	**Low**	Mo...te	**High**

Diagnosis Scoring:
Diagnosis Scoring is 6 points, and therefore this area of MDM is at max

WN in NAO. Alert, Active and responds appropriately to exam.
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Follow Up as needed.

Signoff Information
Electronically Signed By: Harriett Oz, M Don 05/06/2013 at 05:30 PM.

Data & Complexity of Review/Orders:
Nothing is documented as being ordered or reviewed

Prescription drug management is provided through initiation of an antibiotic
TOR: Moderate Risk

Complexity according to the provider?

- What about the provider's assessment and the plan of care of the patient? Is there any indication that the problem is uncomplicated, or does the assessment and POC indicate it is an acute uncomplicated problem?

New Office ○ Established Office ◉
New Hospital ○ Subsequent Hospital ○
Consult ○

E/M Documentation Auditor's Instructions

Reviewer: Shannon DeCond Date of Review: 03/07/2016
Doctor: Harriett Oz, MD Date of Service: 05/06/2013 ID#: Ridersmchidlen

1. History

Refer to data section (table below) in order to quantify. After referring to data, circle the entry farthest to the RIGHT in the table that best describes the HPI, ROS and PFSH. If one column contains three circles, draw a line down that column to the bottom row to identify the type of history. If no column contains three circles, the column containing a circle farthest to the LEFT identifies the type of history. After completing this table that classifies the history, circle the type of history within the appropriate grid in section 5.

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☑ Location ☐ Severity ☐ Timing ☑ Quality ☐ Duration ☐ Context ☐ Associated Signs & Symptoms ☐ Modifying Factors		◉ Brief (1-3)		○ Extended (4 or More)
ROS (Review of Systems): ☑ constitutional ☐ All/Immuno ☐ Ears, nose, mouth, throat ☐ Integumentary ☐ Eyes ☐ Musculo ☐ Neuro ☐ Hem/lymph ☐ Cardiac/ vasc. ☐ GU ☐ Resp ☐ GI ☐ Psych ☐ Endo ☐ All other systems were negative	○ N/A	◉ Pertinent to problem (1 system)	○ Extended (pert & others) (2-9 systems)	○ Complete (pert & all others) (10 systems)
PFSH (Past, Family, Social History): ☑ Past history (the patient's past experiences with illnesses, operations, injuries and treatments) ☐ Family history (a review of medical events in the patient's family, including diseases that may be hereditary or place the patient at risk) ☑ Social history (an age appropriate review of past and current activities)	○ N/A	○ N/A	○ Pertinent 1 history item	◉ Complete 2-3 history areas
* Complete PFSH **2 history areas:** a) established patients - office (outpatient) care, domiciliary care, home care, b) emergency department; c) subsequent nursing facility care, and d) subsequent hospital care **3 history areas:** a) new patients - office (outpatient) care, domiciliary care, home care; b) consultations; c) initial hospital care; d) hospital observation; and e) initial nursing facility care.	PROBLEM FOCUSED 99201 99212	EXPANDED PROBLEM FOCUSED 99201 99213	DETAILED 99203 99214	COMPREHENSIVE 99204/99205 99215
				Final History requires all 3 components above are met or exceeded

Final Result for Complexity

A	Number of diagnosis or treatment options	Minimal	Limited	Multiple	Extensive
B	Amount and complexity of data	Minimal or low	Limited	Multiple	Extensive
C	Highest risk options	Minimal	Low	Moderate	High
Complexity of decision making		**Straight Forward**	**Low**	**Moderate**	**High**

2. Examination

Refer to data section (table below) in order to quantify. After referring to data, identify the type of examination. Circle the type of examination within the appropriate grid in section 5.

CPT Type of Exam	95 Guidelines	97 Guidelines
Problem Focused Exam (**PF**)	○ One body area or organ system	○ 1-5 bulleted elements
Expanded Problem Focused Exam (**EPF**)	○ 2-7 Body Systems - No detail of any system required	○ 6-11 bulleted elements
Detailed Exam (**D**)	○ 2-7 body systems w/affected system in detail	○ 12-17 bulleted elements for 2 or more systems
Comprehensive Exam (**C**)	◉ 8 or more body systems	Not Applicable for 1997 Guidelines
Comprehensive Exam (**C**)	Not Applicable to 1995 Guidelines	○ 18 or more bulleted elements for 9 or more systems See requirements for individual single system exams

5. Level of Service

OUTPATIENT, CONSULTS (OUTPATIENT, INPATIENT & CONFIRMATORY), AND ER

	New Office/Consults requires 3 components within shaded area					*Established Office requires 2 components within shaded area			
History	PF	EPF	D	C	C	PF	EPF	D	C
Examination	PF	EPF	D	C	C	PF	EPF	D	CE
Complexity of Medical Decision	SF	SF	L	M	H	SF	L	M	H
Average time (minutes)	99201=10 NEW OFFICE 99241=15 OUT-PT CONSULT	99202=20 NEW OFFICE 99242=30 OUT-PT CONSULT	99203=30 NEW OFFICE 99243=40 OUT-PT CONSULT	99204=40 NEW OFFICE 99244=60 OUT-PT CONSULT	99205=60 NEW OFFICE 99245=80 OUT-PT CONSULT	99212 = 10 min. Est Office	99213 = 15 min. Est Office	99214 = 25 min. Est Office	99215 = 40 min. Est Office
LEVEL	I	II	III	IV	V	II	III	IV	V

* Level I established visit is for when a patient sees the nurse, not the doctor.

Patient Encounter to be audited: Andy Cheek

Review the CPT/ICD-9 coding on the sample claim form.
Audit the encounter, and answer the questions below.

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)
1. 311 3. 272.2
2. 300.00 4. V58.69

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $CHARGE	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
10	1	14	10	1	14	11		99211		1	75	1		NPI	123456789
														NPI	
														NPI	
														NPI	
														NPI	
														NPI	

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Harriet Oz, M.D. Gregory Peck, M.D. Sadie Piat, M.D. Andrew Wall, M.D.

What do you think of this chief complaint?

Patient: Andy Cheek
DOB: 5-1-1935
10-1-2014

HPI = 2
ROS = 1
PFSH = 3

Modifying factor

Quality

Instead use as constitution ROS

Current Medications
Taking Lexapro IO MG Tablet TAKE 1 TABLET DAILY
Discontinued Diflucan 150 MG Tablet 1 tablet One a day
Discontinued Triamcinolone Acetonide 0.1 % Cream 1 application to affected area Twice a Day medication List reviewed and reconciled with the patient

Past Medical History
Anxiety Depression (300-4) ;

Surgical History
Denies Past Surgical History

Family History
Father: deceased, Father emphysema;
Mother: alive
3 brother(s) , 3 sister(s) . 1 sons) , 1 daughter (s)

Social history
Tobacco Use:
Tobacco Use/Smoking Are you a:
Nonsmoker.
Drugs/Alcohol:
Alcohol Screen
Points a Interpretation *Negative*
Miscellaneous:
Caffeine: none.
Exercise: occasional.

Reason for Appointment
1. Med Refills- Lexapro
2. Needs full fasting labs

History of Present Illness
Interim History:
Here for med refill of Lexapro; reports feeling well; takes Brand Lexapro due to SE's from generic, ie dizziness, lightheadedness. Also requests to have fasting labs ASAP.

Vital Signs
Temp 99 F, HR 68 , BP *114/62* mm Hg, Ht 64 in, Wt 130 lbs, BMI 22.31 Index.

General Examination:
GENERAL APPEARANCE: alert, well hydrated, in no distress.
HEAD: normacephalic.
HEART: SI, S2 normal.
LUNGS: clear to auscultation bilaterally, no wheezes, rales, rhonchi.
EXTREMITIES: full range of motion, no clubbing, cyanosis, or edema.

New Office ○ Established Office ◉
New Hospital ○ Subsequent Hospital ○
Consult ○

E/M Documentation Auditor's Instructions

Reviewer: DeConda, Shannon | Date of Review: 03/07/2016
Doctor: Sadie Piat, MD | Date of Service 10/01/2014 | ID#: Cheek

1. History

Refer to data section (table below) in order to quantify. After referring to data, circle the entry farthest to the RIGHT in the table that best describes the HPI, ROS and PFSH. If one column contains three circles, draw a line down that column to the bottom row to identify the type of history. If no column contains three circles, the column containing a circle farthest to the LEFT identifies the type of history. After completing this table that classifies the history, circle the type of history within the appropriate grid in section 5.

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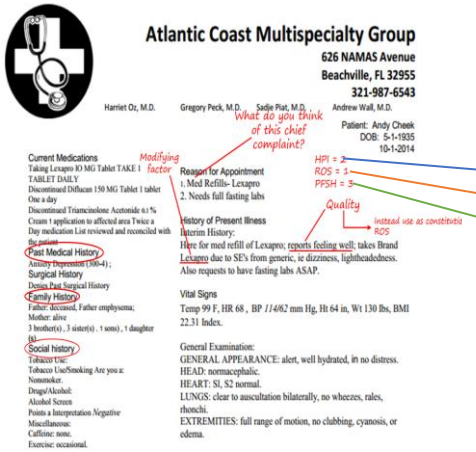

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Harriet Oz, M.D. Gregory Peck, M.D. Sadie Piat, M.D. Andrew Wall, M.D.

Patient: Andy Cheek
DOB: 5-1-1935
10-1-2014

What do you think of this chief complaint?

Modifying factor

HPI = 2
ROS = 1
PFSH = 3

Quality

Instead use as constitutiona ROS

Current Medications
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Past Medical History
Anxiety Depression (300-4) ;

Surgical History
Denies Past Surgical History

Family History
Father: deceased, Father emphysema; Mother: alive
3 brother(s) , 3 sister(s) . 1 sons) , 1 daughter (s) .

Social history
Tobacco Use:
Tobacco Use/Smoking Are you a:
Nonsmoker.
Drugs/Alcohol:
Alcohol Screen
Points a Interpretation *Negative*
Miscellaneous:
Caffeine: none.
Exercise: occasional.

Reason for Appointment
1. Med Refills- Lexapro
2. Needs full fasting labs

History of Present Illness
Interim History:
Here for med refill of Lexapro; reports feeling well; takes Brand Lexapro due to SE's from generic, ie dizziness, lightheadedness.
Also requests to have fasting labs ASAP.

Vital Signs
Temp 99 F, HR 68 , BP *114/62* mm Hg, Ht 64 in, Wt 130 lbs, BMI 22.31 Index.

General Examination:
GENERAL APPEARANCE: alert, well hydrated, in no distress.
HEAD: normacephalic.
HEART: Sl, S2 normal.
LUNGS: clear to auscultation bilaterally, no wheezes, rales, rhonchi.
EXTREMITIES: full range of motion, no clubbing, cyanosis, or edema.

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Harriet Oz, M.D. Gregory Peck, M.D. Sadie Piat, M.D. Andrew Wall, M.D.

Patient: Andy Cheek
DOB: 5-1-1935
10-1-2014

Exam Findings:
1- Constitutional
2- Neuro
3- Psych
4- Cardiovascular
5- Respiratory
6- Musculoskeletal

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Also requests to have fasting labs ASAP.

Vital Signs
(1) Temp 99 F, HR 68 , BP *114/62* mm Hg, Ht 64 in, W
22.31 Index.

General Examination:
GENERAL APPEARANCE: (2) alert, well hydrated, (3) in no distress.
~~HEAD: normacephalic.~~
(4) HEART: Sl, S2 normal.
(5) LUNGS: clear to auscultation bilaterally, no wheezes, rales, rhonchi.
(6) EXTREMITIES: full range of motion, no clubbing, cyanosis, or edema.

Truly cardio, no muscle

Carrier discrepancy with Detailed exam?
EPF: 2+ Organ Systems
D: 2+ Organ systems with one in detail
OR
5-7 Organ Systems

Exam supports EPF Level

Atlantic Coast Multispecialty Group

626 NAMAS Avenue
Beachville, FL 32955
321-987-6543

Harriet Oz, M.D. Gregory Peck, M.D. Sadie Piat, M.D. Andrew Wall, M.D.

Patient: Andy Cheek
DOB: 5-1-1935
10-1-2014

Current Medications
Taking Lexapro IO MG Tablet TAKE 1 TABLET DAILY
Discontinued Diflucan 150 MG Tablet 1 tablet One a day
Discontinued Triamcinolone Acetonide 0.1 % Cream 1 application to affected area Twice a Day medication List reviewed and reconciled with the patient
Past Medical History
Anxiety Depression (300-4) ;
Surgical History
Denies Past Surgical History
Family History
Father: deceased, Father emphysema;
Mother: alive
3 brother(s) , 3 sister(s) . 1 sons) , 1 daughter (s) .
Social history
Tobacco Use:
Tobacco Use/Smoking Are you a:
Nonsmoker.
Drugs/Alcohol:
Alcohol Screen
Points a Interpretation *Negative*
Miscellaneous:
Caffeine: none.
Exercise: occasional.

Reason for Appointment
1. Med Refills- Lexapro
2. Needs full fasting labs

History of Present Illness
Interim History:
Here for med refill of Lexapro; reports feeling well; takes Brand Lexapro due to SE's from generic, ie dizziness, lightheadedness. Also requests to have fasting labs ASAP.

Vital Signs
Temp 99 F, HR 68 , BP *114/62* mm Hg, Ht 64 in, Wt 130 lbs, BMI 22.31 Index.

General Examination:
GENERAL APPEARANCE: alert, well hydrated, in no distress.
HEAD: normacephalic.
HEART: Sl, S2 normal.
LUNGS: clear to auscultation bilaterally, no wheezes, rales, rhonchi.
EXTREMITIES: full range of motion, no clubbing, cyanosis, or edema.

5. Level of Service

OUTPATIENT, CONSULTS (OUTPATIENT, INPATIENT & CONFIRMATORY), AND ER

	New Office/Consults requires 3 components within shaded area					*Established Office requires 2 components within shaded area			
History	PF	EPF	D	C	C	PF	E	D	C
Examination	PF	EPF	D	C	C	PF	EPF	D	C
Complexity of Medical Decision	SF	SF	L	M	H	SF	L	M	H
Average time (minutes)	99201=10 NEW OFFICE 99241=15 OUT-PT CONSULT	99202=20 NEW OFFICE 99242=30 OUT-PT CONSULT	99203=30 NEW OFFICE 99243=40 OUT-PT CONSULT	99204=40 NEW OFFICE 99244=60 OUT-PT CONSULT	99205=60 NEW OFFICE 99245=80 OUT-PT CONSULT	99212 = 10 min. Est Office	99213 = 15 min. Est Office	99214 = 25 min. Est Office	99215 = 40 min. Est Office
LEVEL	I	II	III	IV	V	II	III	IV	V

* Level I established visit is for when a patient sees the nurse, not the doctor.

Documentation addressed as 1 issue not 2 and it is difficult to tell if both were problems addressed due to poor HPI documentation

Marital status: married.
Gyn History
Last Pap smear 04/18/13 WNL.
Last Mammogram 6-9-2012 D/S DENSE, CATE2.
Date of Last Period 3 weeks ago.
Birth Control none.
013 History
Pregnancy # 1: normal spontaneous vaginal delivery (NSVD).

Assessments
1. Depressive Disorder, not elsewhere classified - 311 (Primary)
2. Anxiety State, unspecified - 300.00
3. Mixed Hyperlipidemia - 272.2 — Not addressed
4. Encounter for long-term (current) drug use - VS8.69
Treatment Not a separate diagnosis- this is a result of problem 1/2
Depressive Disorder, not elsewhere classified
LAB ORDERS:
LAB: CBC (INCLUDES DIFF/PLATELET)
LAB: COMP COMPREHENSNE METABOLIC PANEL 1
LAB: LIPID PANEL
LAB:TSH
LAB: VIT B12/FOLATE
LAB: Vitamin D, 25-Hvdroxv
Notes: Cont. Lexapro as directed; recheck labs ASAP and *flu* for review.
Refill of medications given and patient is to return in 3 weeks for
ve.

Diagnosis Findings: Established Stable Problem
1 point
Data R/O: Labs ordered, but not documentation of further work
1 point
TOR: Prescription drug management
Moderate complexity

Final Result for Complexity

A	Number of diagnosis or treatment options	Minimal	Limited	Multiple	Extensive
B	Amount and complexity of data	Minimal	Limited	Multiple	Extensive
C	Highest risk options	Minimal	Low	Moderate	High
Complexity of decision making		Straight Forward	**Low**	**Moderate**	**High**

New Office ○ Established Office ◉
New Hospital ○ Subsequent Hospital ○
Consult ○

E/M Documentation Auditor's Instructions

Reviewer: DeConda, Shannon | Date of Review: 03/07/2016
Doctor: Sadie Piat, MD | Date of Service 10/01/2014 | ID# Cheek

1. History

Refer to data section (table below) in order to quantify. After referring to data, circle the entry farthest to the RIGHT in the table that best describes the HPI, ROS and PFSH. If one column contains three circles, draw a line down that column to the bottom row to identify the type of history. If no column contains three circles, the column containing a circle farthest to the LEFT identifies the type of history. After completing this table that classifies the history, circle the type of history within the appropriate grid in section 5.

HPI (History of Present Illness): Characterize HPI by considering **EITHER** the status of 3 chronic or inactive conditions OR the number of elements recorded.				○ Status of 3 Chronic Conditions
☐ Location ☐ Severity ☐ Timing ☐ Associated Signs & Symptoms ☐ Quality ☐ Duration ☐ Context ☑ Modifying Factors		◉ Brief (1-3)		○ Extended (4 or More)
ROS (Review of Systems): ☑ Constitutional ☐ All/Immuno ☐ Ears, nose, mouth, throat ☐ Integumentary ☐ Eyes ☐ Musculo ☐ Neuro ☐ Hem/lymph ☐ Cardiac/ vasc. ☐ GU ☐ Resp ☐ GI ☐ Psych ☐ Endo ☐ All other systems were negative	○ N/A	◉ Pertinent to problem (1 system)	○ Extended (pert & others) (2-9 systems)	○ Complete (pert & all others) (10 systems)
PFSH (Past, Family, Social History): ☑ **Past history** (the patient's past experiences with illnesses, operations, injuries and treatments) ☑ **Family history** (a review of medical events in the patient's family, including diseases that may be hereditary or place the patient at risk) ☑ **Social history** (an age appropriate review of past and current activities)	○ N/A	○ N/A	◉ Pertinent t history item	◉ Complete 2-3 history areas
* Complete PFSH **2 history areas:** a) established patients - office (outpatient) care, domiciliary care, home care; b) emergency department; c) subsequent nursing facility care; and d) subsequent hospital care. **3 history areas:** a) new patients - office (outpatient) care, domiciliary care, home care; b) consultations; c) initial hospital care; d) hospital observation; and e) initial nursing facility care.	PROBLEM FOCUSED 99201 99212	EXPANDED PROBLEM FOCUSED 99202 99213	DETAILED 99203 99214	COMPRE-HENSIVE 99204/99205 99215
	Final History requires all 3 components above are met or exceeded			

2. Examination

Refer to data section (table below) in order to quantify. After referring to data, identify the type of examination. Circle the type of examination within the appropriate grid in section 5.

CPT Type of Exam	95 Guidelines	97 Guidelines
Problem Focused Exam **(PF)**	○ One body area or organ system	○ 1-5 bulleted elements
Expanded Problem Focused Exam **(EPF)**	2-7 Body Systems or detail of any system required	○ 6-11 bulleted elements
Detailed Exam **(D)**	○ 2-7 body systems w/affected system in detail	○ 12-17 bulleted elements for 2 or more systems
Comprehensive Exam **(C)**	○ 8 or more body systems	Not Applicable for 1997 Guidelines
Comprehensive Exam **(C)**	Not Applicable to 1995 Guidelines	○ 18 or more bulleted elements for 9 or more systems. See requirements for individual single system exams

Final Result for Complexity

A	Number of diagnosis or treatment options	Minimal	Limited	Multiple	Extensive
B	Amount and complexity of data	Minimal	Limited	Multiple	Extensive
C	Highest risk options	Minimal	Low	Moderate	High
Complexity of decision making		Straightforward	**Low**	**Moderate**	**High**

5. Level of Service

OUTPATIENT, CONSULTS (OUTPATIENT, INPATIENT & CONFIRMATORY), AND ER

	New Office/Consults requires 3 components within shaded area					*Established Office requires 2 components within shaded area			
History	PF	EPF	D	C	C	PF	EPF	D	C
Examination	PF	EPF	D	C	C	PF	EPF	D	C
Complexity of Medical Decision	SF	SF	L	M	H	SF	L	M	H
Average time (minutes)	99201=10 NEW OFFICE 99241=15 OUT-PT CONSULT	99202=20 NEW OFFICE 99242=30 OUT-PT CONSULT	99203=30 NEW OFFICE 99243=40 OUT-PT CONSULT	99204=40 NEW OFFICE 99244=60 OUT-PT CONSULT	99205=60 NEW OFFICE 99245=80 OUT-PT CONSULT	99212 = 10 min. Est Office	99213 = 25 min. Est Office	99214 = 25 min. Est Office	99215 = 40 min. Est Office
LEVEL	I	II	III	IV	V	II	III	IV	V

* Level I established visit is for when a patient sees the nurse, not the doctor.

Patient Encounter to be audited:
Andy Cheek

Review the CPT/ICD-9 coding on the sample claim form.
Audit the encounter, and answer the questions below.

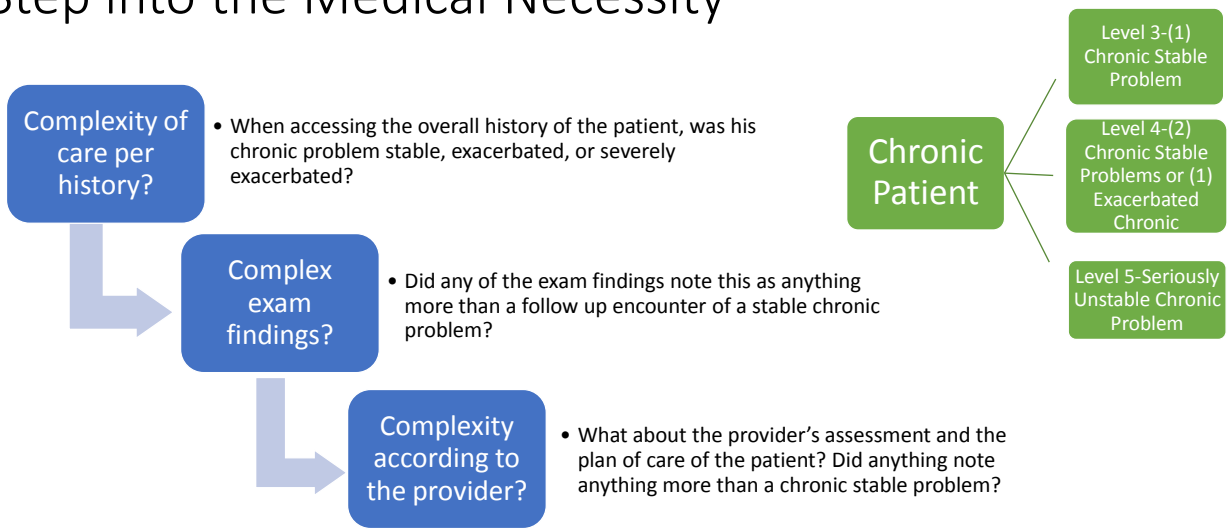
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)
1. 311 3. 272.2
2. 300.00 4. V58.69

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $CHARGE	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
10 1 14	10 1 14	11		99211		1	75	1		NPI	12456789
										NPI	
										NPI	
										NPI	
										NPI	
										NPI	

Review Questions:
1. Is a 99211 supported in this encounter?
2. What LOS did the documentation support?
3. Should the auditor have any comments for the provider regarding a 99211 in this scenario?
4. What about medical necessity?

Step into the Medical Necessity



Documentation Scoring

- Documentation 99213
- Medical Necessity 99213

- Overall level of service supported is a 99213 encounter

For More Information

Shannon DeConda
sdeconda@drsmgmt.com
877-418-5564