# E & M Chart Audit for the Allergy Practice

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## Physician Documentation

- Verification that the coding is appropriate to the documentation
- Education and training if inappropriate coding
- Refunding third party payers if payments have been received

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Patient DOB MRN
Facility Encounter Date

**History** *Chief Complaint is required in ALL documentation*

| Components | Criteria | | | |
|---|---|---|---|---|
| **HPI** (History of Present Illness)<br>**Status of 3 chronic problems**<br>❑1 ❑2 ❑3<br>*OR*<br>**Choose Elements**<br>❑Quality ❑Location ❑Duration ❑Severity<br>❑Timing ❑Context ❑Modifying factors<br>❑Associated Signs/Symptoms | ❑ Status of 1-2 Chronic Conditions *OR* ❑ *Brief* 1-3 Elements | ❑ Status of 1-2 Chronic Conditions *OR* ❑ *Brief* 1-3 Elements | ❑ Status of 3 Chronic Conditions *OR* ❑ *Extended* ≥4 Elements | ❑ Status of 3 Chronic Conditions *OR* ❑ *Extended* ≥4 Elements |
| **ROS** (Review of Systems)<br>❑Constitutional ❑ENT ❑Eyes<br>❑CV ❑Skin/Breasts<br>❑Resp ❑Endo<br>❑GI ❑GU ❑Heme/Lymph<br>❑MS ❑Neuro ❑Psych<br>❑Allergy/Immunology | NA | ❑ *Pertinent to Problem* 1 | ❑ *Extended* (Pertinent to problem and other related systems) **2-9 Total** | ❑ *Complete* (Pertinent and all related systems) **10 Total** |
| **PFSH** (Past Medical, Family Social History)<br>❑Past History (Illnesses, Surgeries, Injuries)<br>❑Past Family (Diseases, Hereditary Illnesses)<br>❑Social (Review of current, past activities) | NA | NA | ❑ *Pertinent* 1 Area | ❑ **Complete* **2-3** Areas |
| *Complete PFSH<br>*3 history areas for ALL NEW Patients*<br>*2 history areas for ALL Follow Up/Established Visits*<br>*OR Patients seen in Emergency Department* | ❑ **Problem Focused** | ❑ **Expanded Problem Focused** | ❑ **Detailed** | ❑ **Comprehensive** |

***ALL Criteria for selected level MUST be MET or EXCEEDED***

**Examination**

| Exam description | 1995 Guideline | 1997 Guideline | Type of Exam |
|---|---|---|---|
| Limited to affected body area or organ system | ❑1 Body Area or Organ System | ❑1-5 Bulleted Items | ❑ **Problem Focused** |
| Affected body area/organ system and other symptomatic or related organ systems | ❑2-7 | ❑6-11 or more | ❑ **Expanded Problem Focused** |
| Extended exam of affected body areas/organ systems and other symptomatic or related organ systems | ❑2-7 | ❑12-17 or more for 2 or more systems | ❑ **Detailed** |
| General Multi-System | ❑≥ 8 | ❑18 or more for 9 or more systems | ❑ **Comprehensive** |
| Complete Single Organ System | Not Defined | Refer to Guideline | |

**See 1995 or 1997 Guidelines for Evaluation & Management Services for specific requirements**





Patient DOB MRN
Facility Encounter Date

**A. Complexity of Medical Decision Making**

**Number of Diagnoses or Treatment Options**

| Problem (Status) | | (Number Number | x Points | = Result) Result |
|---|---|---|---|---|
| Self-limited or minor (stable, improved or worsening) | Max = 2 | | 1 | |
| Est. problem (to examiner) *stable, improved* | | | 1 | |
| Est. problem (to examiner) *worsening* | | | 2 | |
| New problem (to examiner) *no additional workup planned* | Max = 1 | | 3 | |
| New problem (to examiner) *additional workup planned* | | | 4 | |
| Check corresponding box below on Line A **Final Result for Complexity of MDM** | | | **Total** | |

MDM = Medical Decision Making

**B. Amount and/or Complexity of Data Reviewed**

| Reviewed Data | Points |
|---|---|
| Review and/or Order of lab tests | 1 |
| Review and/or Order of tests in the radiology section of CPT | 1 |
| Review and/or Order of tests in the medicine section of CPT | 1 |
| Discussion of test results with performing physician | 1 |
| Decision to obtain old records and/or obtain history from someone other than the patient | 1 |
| Review and summarization of old records and/or obtaining history from someone other than the patient and/or discussion of case with another health care provider | 2 |
| Independent visualization of image, specimen or tracing (NOT simply review of report) | 2 |
| Check corresponding box below on Line B of **Final Result for Complexity of MDM** | **TOTAL** |

MDM = Medical Decision Making

**C. Risk of Complications, Morbidity and/or Mortality**

Choose highest risk level and select corresponding risk level on line B in Final Result for Complexity

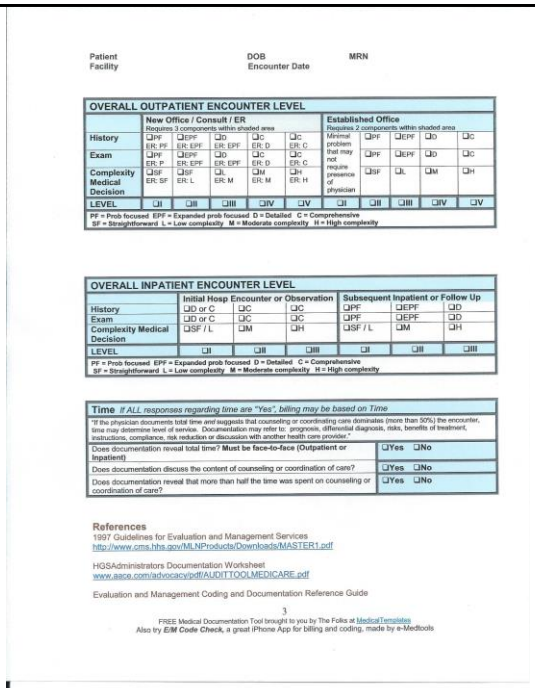
| Risk | Presenting problems | Dx procedures ordered | Management options |
|---|---|---|---|
| ***Min*** ❑ | 1 minor or self-limited ❑ | Venipuncture, CXR, EKG, EEG ❑ | Rest, elastic bandages ❑ |
| ***Low*** ❑ | 2 or more minor<br>1 stable chronic problem<br>Acute uncomp illness/injury ❑ | Physiol tests NOT under stress<br>Non CV imaging with contrast<br>Superficial needle biopsies ❑ | OTC drugs, PT, OT<br>IV fluids without additives<br>Minor surgery NO risk factors ❑ |
| ***Mod*** ❑ | Mild exac ≥ 1 chron prob<br>≥2 stable chron prob<br>Acute illness + systemic Sx<br>Acute complicated injury ❑ | Physiologic tests under stress<br>Dx endoscopies NO risk factors<br>Deep needle or incisional bx<br>CV imaging + contrast<br>Obtain fluid from body cavity ❑ | Minor surgery + risk factors<br>Elective major surgery<br>Prescription drug therapy<br>Therapeutic nuclear medicine<br>IV fluids + additives ❑ |
| ***High*** ❑ | Sev exac, ≥1 chron prob<br>Acute or chronic illness posing threat to life/limb<br>Abrupt change neuro status ❑ | CV imaging + contrast, risk factors<br>Card electrophysiologic studies<br>Dx endoscopies + risk factors<br>Discography ❑ | Elective maj surg + risk factors<br>Emergency major surgery<br>Parenteral controlled sub<br>Rx requiring intense monitoring<br>DNR or de-escalation of care ❑ |

Check corresponding box below on Line C of **Final Result for Complexity of MDM**

**Final Result for Complexity of Medical Decision Making**

The column with 2 or 3 circles determines overall complexity of Medical Decision Making

| | | | | | |
|---|---|---|---|---|---|
| A | **Number Tx Options** *See TOTAL above in Box A* | ❑1 or less *Minimal* | ❑2 *Limited* | ❑3 *Multiple* | ❑4 *Extensive* |
| B | **Amount of Data** *See TOTAL above in Box B* | ❑1 or less *Minimal* | ❑2 *Limited* | ❑3 *Multiple* | ❑4 *Extensive* |
| C | **Highest Risk** *See Box C Above* | ❑*Minimal* | ❑*Low* | ❑*Moderate* | ❑*High* |
| | **Decision Making Level** | ❑**SF** | ❑**Low** | ❑**Moderate** | ❑**High** |



Patient
Facility

DOB
Encounter Date

MRN

**OVERALL OUTPATIENT ENCOUNTER LEVEL**

| | New Office / Consult / ER<br>Requires 3 components within shaded area | | | | | Established Office<br>Requires 2 components within shaded area | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| History | ❑PF<br>ER: PF | ❑EPF<br>ER: EPF | ❑D<br>ER: EPF | ❑C<br>ER: D | ❑C<br>ER: C | Minimal problem that may not require presence of physician | ❑PF | ❑EPF | ❑D | ❑C |
| Exam | ❑PF<br>ER: P | ❑EPF<br>ER: EPF | ❑D<br>ER: EPF | ❑C<br>ER: D | ❑C<br>ER: C | | ❑PF | ❑EPF | ❑D | ❑C |
| Complexity Medical Decision | ❑SF<br>ER: SF | ❑SF<br>ER: L | ❑L<br>ER: M | ❑M<br>ER: M | ❑H<br>ER: H | | ❑SF | ❑L | ❑M | ❑H |
| LEVEL | ❑I | ❑II | ❑III | ❑IV | ❑V | | ❑I | ❑II | ❑III | ❑IV | ❑V |

PF = Prob focused EPF = Expanded prob focused D = Detailed C = Comprehensive
SF = Straightforward L = Low complexity M = Moderate complexity H = High complexity

**OVERALL INPATIENT ENCOUNTER LEVEL**

| | Initial Hosp Encounter or Observation | | | Subsequent Inpatient or Follow Up | | |
|---|---|---|---|---|---|---|
| History | ❑D or C | ❑C | ❑C | ❑PF | ❑EPF | ❑D |
| Exam | ❑D or C | ❑C | ❑C | ❑PF | ❑EPF | ❑D |
| Complexity Medical Decision | ❑SF / L | ❑M | ❑H | ❑SF / L | ❑M | ❑H |
| LEVEL | ❑I | ❑II | ❑III | ❑I | ❑II | ❑III |

PF = Prob focused EPF = Expanded prob focused D = Detailed C = Comprehensive
SF = Straightforward L = Low complexity M = Moderate complexity H = High complexity

**Time** *If ALL responses regarding time are "Yes", billing may be based on Time*

"If the physician documents total time *and* suggests that counseling or coordinating care dominates (more than 50%) the encounter, time may determine level of service. Documentation may refer to: prognosis, differential diagnosis, risks, benefits of treatment, instructions, compliance, risk reduction or discussion with another health care provider."

| | |
|---|---|
| Does documentation reveal total time? **Must be face-to-face (Outpatient or Inpatient)** | ❑Yes ❑No |
| Does documentation discuss the content of counseling or coordination of care? | ❑Yes ❑No |
| Does documentation reveal that more than half the time was spent on counseling or coordination of care? | ❑Yes ❑No |

**References**

1997 Guidelines for Evaluation and Management Services
http://www.cms.hhs.gov/MLNProducts/Downloads/MASTER1.pdf

HGSAdministrators Documentation Worksheet
www.aaco.com/advocacy/pdf/AUDITTOOLMEDICARE.pdf

Evaluation and Management Coding and Documentation Reference Guide

3

FREE Medical Documentation Tool brought to you by The Folks at MedicalTemplates
Also try ***E/M Code Check***, a great iPhone App for billing and coding, made by e-Medtools

# Diagnosis Coding

- The diagnoses need to be specific
- Remember place the diagnosis with the most acuity first
- Acute precedes chronic
- Co-morbidities – you need to address how the comorbidity affect the allergy/asthma issues
- List the co-morbidities after your dx
- If you code it make sure it is in the documentation
- Medical necessity is defined with diagnosis codes



# General Coding Guidelines

- Locating a code in ICD-10CM
  - First locate the term in the Alphabetic Index, and then verify the code in the Tabular List
  - Read and be guided by instructional notations that appear in both the Alphabetic Index and the Tabular List
  - Selection of the full code, including laterality and any applicable 7th character can only be done in the Tabular List. A dash (-) at the end of an Alphabetic Index entry indicates that additional characters are required.
  - Read instructional notations that appear in both alphabetic Index and tabular index
- Diagnosis Codes are to be reported at their highest level of specificity – and use the highest number of characters available




# ICD-10CM Coding Guidelines

- Codes are composed of codes with 3-7 characters
  - A three character code may be used as well as a seven character code. Three character codes may also be used as headings for a subcategory of codes further specified.
- Codes will be from A00.0 through T88.9, Z00-Z99.8
- Codes describing signs and symptoms are acceptable for reporting when a related definitive diagnosis has not been confirmed by the provider
- Chapter 18 - R00.0-R99 contain most of the signs, symptoms and abnormal clinical and lab finding codes

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# ICD-10CM Coding Guidelines

- Conditions that are an integral part of the disease process that are associated routinely with a disease process should not be assigned as additional codes; unless otherwise instructed
- Conditions that are not an integral part should be coded when present
- “Use additional code” notes are found in the tabular section
- “Code first” guidelines will also be found in the tabular section



# ICD10 Coding Guidelines

- Acute and chronic conditions can be coded together when there are **separate subentries** that exist in the Alphabetic Index at the same indentation level; sequence the acute first and the chronic secondary

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# ICD-10CM Coding Guidelines

- Each unique ICD-10-CM diagnosis code may be reported only once for an encounter. This applies to bilateral conditions when there are no distinct codes identifying laterality or two different conditions classified to the same ICD-10-CM diagnosis code.
- **Laterality - this will be a place holder**
  - Right side - 1
  - Left side - 2
  - Bilateral - 3
  - Unspecified side -0-



# Sequela (Late Effects)

- A sequela is the residual effect (condition produced) after the acute phase of an illness or injury has terminated. There is no time limit on when a sequela code can be used. The residual may be apparent early, such as in cerebral infarction, or it may occur months or years later, such as that due to a previous injury. Coding of sequela generally requires two codes sequenced in the following order: The condition or nature of the sequela is sequenced first. The sequela code is sequenced second.

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## Chapter 10 Disease of the Respiratory System – chapter instructions

Note: When a respiratory condition is described as occurring in more than one site and is not specifically indexed, it should be classified to the lower anatomic (e.g. tracheobronchitis to bronchitis in J40)

Use additional code where applicable to identify:

Exposure to environmental tobacco smoke (Z72.22)

Exposure to tobacco smoke in the perinatal period (P96.81)

History of tobacco use (Z87.891)

Occupational exposure to environmental tobacco smoke (z57.31)

Tobacco dependence (F17.-)

Tobacco use (Z72.0)



## Example

- New patient E & M provided
- Allergy testing and PFT performed
- Diagnoses at the conclusion of the visit are:
  1. Allergic rhinitis due to pollens J30.1
  2. Allergic rhinitis due to house dust mites J30.89
  3. Atopic dermatitis L 20.89
  4. Allergic conjunctivitis H10.45
  5. Mild persistent asthma – J45.30
  6. History of peanut allergy – Z91.010
  7. Post nasal drip unrelated – R09.82

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# Diagnosis Coding

- Chapter 19 – Injuries, poisoning and certain other consequences of external causes requires the 7th character
  - A – Initial encounter while the patient is receiving active treatment for the condition. Examples of active treatment – emergency department encounter and evaluation and continuing treatment by the same or a different physician
  - D – Subsequent encounter is used for encounters after the patient has received active treatment of the condition and is receiving routine care for the condition during the healing or recovery phase. Examples medication adjustment, other aftercare and follow up visits following treatment of the injury or condition.
  - S – The residual effect (condition produced) after the acute phase of an illness has terminated. There is no time limit. Sequela coding generally requires two codes sequenced in the following order: the condition or nature of the sequela is sequenced first. The sequela code is sequenced second.




# Diagnosis Coding

- Chapter 19 - Subsection guidelines for Poisoning by, adverse effects of and under-dosing of drugs, medicaments and biological substances (T36-T50)
  - Includes adverse effect of correct substance properly administered
  - Poisoning by wrong substance given or taken in error
  - Poisoning by overdose of substance
  - Under-dosing by (inadvertently)(deliberately) taking less substance than prescribed or instructed
- Code first, for adverse effects, the nature of the adverse
  - Dermatitis due to substances taken internally
  - Urticaria
  - Pruritus
  - Erythema
- Codes from the T36-T50 will be sequenced second

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# Diagnosis Coding

- Status - Indicates that a patient is either a carrier of a disease or has the sequelae or residual of a past disease or condition.
  - The status code is informative, because the status may affect the course of treatment and its outcome.
- History – Indicates that the patient no longer has the condition
- Do not use the status code with a diagnosis code from one of the body system chapters if the diagnosis code includes the information provided by the status code
- Alphabetical index list food and bee Z codes under “history – personal – allergy”



# Diagnosis Coding

- Z codes
  - Z codes may be listed as the primary diagnosis code
  - Z23 is for encounters for vaccinations. The procedure code required will identify the actual administration of the injection and the type(s) of immunizations given.
  - Z01.82 – “Encounter for allergy testing without complaint, suspected or reported diagnosis”
  - Z51.6 – Encounter for desensitization to allergens
  - Z88.--- - Allergy status to drugs, medications and biological substances

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# Diagnosis coding – support for your claim

- Are the additional codes for smoking, exposure to smoking, etc required?
- What does the Excludes 1 mean in the ICD-10CM book?
- Our physician treats a patient for allergies and asthma. However, this patient also has hypertension, ICD10 code I10. The physician reviews his medications for this condition and how they might interact with his allergy/asthma medications. The physician's medical decision making process takes into account the patient's hypertension, and this is documented in the chart notes.
- Question: Is it appropriate to add the diagnosis of I10 for hypertension?




# E/M Code Criteria

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# Components of the E & M

- History
- Exam
- Medical decision making




# Requirement for New/Consult Patient vs. Established Patient

- History, exam & medical decision making need to be at the same level or higher to support the level of care
- Two of the three of the components at the same level or higher to support the level of care
- The history and exam must be appropriate to the patient's presenting problem

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| **CONSULT-HOSPITAL** | **99251** | **99252** | **99253** | **99254** | **99255** |
|---|---|---|---|---|---|
| **CONSULT-3 of 3** | **99241** | **99242** | **99243** | **99244** | **99245** |
| **NEW PT- 3 of 3** | **99201** | **99202** | **99203** | **99204** | **99205** |
| | | | | | |
| **HISTORY** | | | | | |
| CHIEF COMPLAINT | Required | Required | Required | Required | Required |
| HX of PRESENT ILL | Brief***(1-3)*** | Brief***(1-3)*** | Extended**(4+)** | Extended**(4+)** | Extended**(4+** |
| REVIEW OF | | Problem | Extended | Complete | Complete |
| SYSTEMS | | Pertinent **(1)** | (**2-9** System) | (**10 +** system) | (**10+** system) |
| PAST HX | | | Pertinent-1 | Complete-1ea | Complete-1ea |
| FAMILY HX | | | Pertinent-1 | Complete-1ea | Complete-1ea |
| SOCIAL HX | | | Pertinent-1 | Complete-1ea | Complete-1ea |
| | | | | | |
| | Perform/ | Perform/ | Perform/ | Perform/ | Perform |
| **EXAM** | document | document | document | document | document |
| | **1-5** elements | at least **6** | at least **12** | all elements: | all elements: |
| | | elements | elements | all elem-shade | all elem -shade |
| | | | | 1 ele-unshaded | 1 ele-unshaded |
| | | | | | |
| **MED. DEC MAKING** | ***(2 of the 3 must be met or exceeded)*** | | | | |
| MGMT OPT. & DX. | Minimal (1) | Minimal (1) | Limited (2) | Multiple (3) | Extensive(4) |
| AMT DATA &COMPLEX | Minimal(1) | Minimal (1) | Limited (2) | Moderate (3) | Extensive(4) |
| RISK OF COMPLICAT. | Minimal | Minimal | Low | Moderate | High |

| **ESTABLISH PT** | | | | | |
|---|---|---|---|---|---|
| **2 OF 3** | **99211** | **99212** | **99213** | **99214** | **99215** |
| | | | | | |
| **HISTORY** | | | | | |
| CHIEF COMPLAINT | Required | Required | Required | Required | Required |
| HX PRESENT ILL. | | Brief | Brief | Extended | Extended |
| SYSTEM REVIEW | | | Prob. Pertinent | Extended | Complete |
| PAST HISTORY | | | | Pertinent-1 | Complete: |
| FAMILY HISTORY | | | | Pertinent-1 | Choice of 2 |
| SOCIAL HISTORY | | | | Pertinent-1 | ele PFS Hx. |
| | | | | | |
| | | Perform/ | Perform/ | Perform/ | Perform/ |
| **EXAM** | | document | document | document | document |
| | | **1-5** elements | at least **6** | at least **12** | all elements: |
| | | | elements | elements | all elem-shade |
| | | | | | 1 ele-unshaded |
| **MED. DEC MAKING** | | | | | |
| MGMT/OPTION DX | | Minimal (1) | Limited (2) | Multiple (3) | Extensive(4) |
| AMT DATA/COMPLEX | | Minimal(1) | Limited(2) | Moderate(3) | Extensive(4) |
| RISK OF COMPLICAT. | | Minimal | Low | Moderate | High |

# History Audit Sheet

- HPI:  Chief Complaint –Reason for encounter
  - Location – specific to area of the body
  - Quality – describe the pain – dull sharp;  wound jagged, dirty or clean
  - Severity – measure on a scale
  - Duration- how long, since when, etc.
  - Context- how complaint occurred
  - Modifying factor- what has alleviated symptoms
  - Signs and symptoms – additional information from patient




# History Audit Sheet

- Review of Systems:
  - Ten are required for a complete ROS
  - Pertinent positives and negatives must be documented
  - A notation of negative for the remaining review of systems may be documented for the remaining systems
  - Can be documented by staff patient
  - Must be reviewed by physician
  - Can be separate or part of the HPI
  - Cannot use one statement in both categories

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# History Audit Sheet

- Past, Family and Social History:
  - Past – Events in the patient's past medical/surgery history
  - Family – Diseases that impact patient's health
  - Social - Factors which are age appropriate that impact from an environmental and social pattern




# 1995 Exam Components

- Problem Focused: One organ system
- Expanded Problem Focused: Two or more organ systems (2-4)
- Detailed: Two or more with detailed information (5-7)
- Comprehensive: Eight or more organ systems

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# Allergy/Immunology Exam – 1997 Guidelines

- PF – 5 elements
- EPF – 6 elements
- Detailed – 12 elements
- Comprehensive – all elements from shaded and 1 element from each un-shaded area




# Constitutional (all)

- 3 vital signs
- Appearance

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# Head & Face (all)

- Head & face
- Palpation or percussion of face




# Eyes (one)

- Inspection of conjunctivae and lids

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## Ears, Nose, Mouth & Throat (all)

- Otoscopic exam of auditory canals, tympanic membrane
- Inspect nasal mucosa, septum & turbs
- Inspect teeth & gums
- Examine oropharynx




## Neck (one)

- Neck
- Thyroid

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# Respiratory (all)

- Auscultation of lungs
- Assess respiratory effort




# Cardiovascular (all)

- Auscultation of heart
- Observation and palpation of peripheral vascular system

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# Gastrointestinal (all) (abdominal)

- Examination of abdomen
- Examination of liver & spleen




# Lymphatic (one)

- Palpation of lymph nodes in neck, axillae, groin or other location

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# Extremities (one)

- Inspection and palpation of digits & nails




# Neurologic/psychiatric (one)

- Time, place, person orientation
- Mood and affect

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# Other

- Additional exam components the physician determines is appropriate for the patient's presenting problem




# Medical Decision Making

- Number of diagnosis and treatment options
- Amount of data and complexity of data
- Risk

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## Number of Diagnosis & Treatment Options

- New problem
- Established problem stable
- Established problem worsening
- Established problem, improved
- Workup planned
- No workup planned



## Amount & Complexity of Data

- Review/order lab tests
- Review/order routine x-rays
- Review/order medicine tests
- Discussion of tests results  with performing physician
- Decision to obtain old records & document
- Direct visualization & independent interpretation documented

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# Risk

- Presenting problem
- Diagnostic procedure
- Management options




# Presenting Problem

- Minimal:
  - One self limited or minor problem
- Low:
  - Two or more self-limited or minor problems
  - One stable chronic illness
  - Acute uncomplicated illness/injury

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# Presenting problem, con't.

- Moderate:
  - One or more chronic illness with mild exacerbation
  - Two or more stable chronic illnesses
  - Undiagnosed new problem with uncertain prognosis
  - Acute illness with systemic symptoms
  - Acute complicated injury




# Presenting Problem, con't.

- High:
  - Chronic illness with severe exacerbation
  - Acute or chronic illness/injury that may pose a threat to life or bodily function

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# Diagnostic Procedures Ordered

- Minimal:
  - Lab tests requiring veni-puncture
  - X-rays
  - Ultrasounds
- Low:
  - Superficial need biopsies
  - Skin biopsies
  - Pulmonary function tests




# Diagnostic Procedures, con't.

- Moderate:
  - Diagnostic endoscopy
  - Deep needle or incisional biopsy
- High:

  Diagnostic endoscopy with risk factors

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# Management Options

- Minimal:
  - Rest
  - Gargles
  - Elastic/superficial dressings
- Low:
  - Over the counter drugs – saline washes
  - Minor surgery – ear piercing
  - Physical Therapy



# Management Options, con't.

- Moderate:
  - Minor surgery with risk
  - Elective major surgery
  - Prescription drug management
  - Closed treatment of fracture w/o manipulation

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# Management Options, con't.

- High:
  - Elective major surgery with risk
  - Emergency major surgery
  - Decision not to resuscitate or de-escalate care because of poor prognosis
  - Drug therapy requiring intensive monitoring for toxicity
  - High morbidity mortality without treatment



# What about Time?

- Time is only used if more than 50% of the encounter is counseling and co-ordination of care. You must document:
  1. Total face to face time
  2. The amount which was counseling
  3. The counseling and coordination of care discussion

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Patient DOB MRN
Facility Encounter Date

**History** *Chief Complaint is required in ALL documentation*

| Components | Criteria | | | |
|---|---|---|---|---|
| **HPI** (History of Present Illness)<br>**Status of 3 chronic problems**<br>❑1 ❑2 ❑3<br>*OR*<br>**Choose Elements**<br>❑Quality ❑Location ❑Duration ❑Severity<br>❑Timing ❑Context ❑Modifying factors<br>❑Associated Signs/Symptoms | ❑ Status of 1-2 Chronic Conditions *OR*<br>❑ *Brief* 1-3 Elements | ❑ Status of 1-2 Chronic Conditions *OR*<br>❑ *Brief* 1-3 Elements | ❑ Status of 3 Chronic Conditions *OR*<br>❑ *Extended* ≥4 Elements | ❑ Status of 3 Chronic Conditions *OR*<br>❑ *Extended* ≥4 Elements |
| **ROS** (Review of Systems)<br>❑Constitutional ❑ENT ❑Eyes<br>❑CV ❑Skin/Breasts<br>❑Resp ❑Endo<br>❑GI ❑GU ❑Heme/Lymph<br>❑MS ❑Neuro ❑Psych<br>❑Allergy/Immunology | NA | ❑ *Pertinent to Problem*<br>1 | ❑ *Extended* (Pertinent to problem and other related systems)<br>**2-9 Total** | ❑ *Complete* (Pertinent and all related systems)<br>**10 Total** |
| **PFSH** (Past Medical, Family Social History)<br>❑Past History (Illnesses, Surgeries, Injuries)<br>❑Past Family (Diseases, Hereditary Illnesses)<br>❑Social (Review of current, past activities) | NA | NA | ❑ *Pertinent*<br>1 Area | ❑ **Complete*<br>**2-3** Areas |
| *Complete PFSH<br>*3 history areas for ALL NEW Patients*<br>*2 history areas for ALL Follow Up/Established Visits*<br>*OR Patients seen in Emergency Department* | ❑ **Problem Focused** | ❑ **Expanded Problem Focused** | ❑ **Detailed** | ❑ **Comprehensive** |

***ALL Criteria for selected level MUST be MET or EXCEEDED***

**Examination**

| Exam description | 1995 Guideline | 1997 Guideline | Type of Exam |
|---|---|---|---|
| Limited to affected body area or organ system | ❑1 Body Area or Organ System | ❑1-5 Bulleted Items | ❑ **Problem Focused** |
| Affected body area/organ system and other symptomatic or related organ systems | ❑2-7 | ❑6-11 or more | ❑ **Expanded Problem Focused** |
| Extended exam of affected body areas/organ systems and other symptomatic or related organ systems | ❑2-7 | ❑12-17 or more for 2 or more systems | ❑ **Detailed** |
| General Multi-System | ❑≥ 8 | ❑18 or more for 9 or more systems | ❑ **Comprehensive** |
| Complete Single Organ System | Not Defined | Refer to Guideline | |

**See 1995 or 1997 Guidelines for Evaluation & Management Services for specific requirements**





Patient DOB MRN
Facility Encounter Date

**A. Complexity of Medical Decision Making**

**Number of Diagnoses or Treatment Options**

| Problem (Status) | | (Number Number | x Points | = Result) Result |
|---|---|---|---|---|
| Self-limited or minor (stable, improved or worsening) | Max = 2 | | 1 | |
| Est. problem (to examiner) *stable, improved* | | | 1 | |
| Est. problem (to examiner) *worsening* | | | 2 | |
| New problem (to examiner) *no additional workup planned* | Max = 1 | | 3 | |
| New problem (to examiner) *additional workup planned* | | | 4 | |
| Check corresponding box below on Line A **Final Result for Complexity of MDM** | | | **Total** | |

MDM = Medical Decision Making

**B. Amount and/or Complexity of Data Reviewed**

| Reviewed Data | Points |
|---|---|
| Review and/or Order of lab tests | 1 |
| Review and/or Order of tests in the radiology section of CPT | 1 |
| Review and/or Order of tests in the medicine section of CPT | 1 |
| Discussion of test results with performing physician | 1 |
| Decision to obtain old records and/or obtain history from someone other than the patient | 1 |
| Review and summarization of old records and/or obtaining history from someone other than the patient and/or discussion of case with another health care provider | 2 |
| Independent visualization of image, specimen or tracing (NOT simply review of report) | 2 |
| Check corresponding box below on Line B of **Final Result for Complexity of MDM** | **TOTAL** |

MDM = Medical Decision Making

**C. Risk of Complications, Morbidity and/or Mortality**

Choose highest risk level and select corresponding risk level on line B in Final Result for Complexity

| Risk | Presenting problems | Dx procedures ordered | Management options |
|---|---|---|---|
| ***Min*** ❑ | 1 minor or self-limited ❑ | Venipuncture, CXR, EKG, EEG ❑ | Rest, elastic bandages ❑ |
| ***Low*** ❑ | 2 or more minor<br>1 stable chronic problem<br>Acute uncomp illness/injury ❑ | Physiol tests NOT under stress<br>Non CV imaging with contrast<br>Superficial needle biopsies ❑ | OTC drugs, PT, OT<br>IV fluids without additives<br>Minor surgery NO risk factors ❑ |
| ***Mod*** ❑ | Mild exac ≥ 1 chron prob<br>≥2 stable chron prob<br>Acute illness + systemic Sx<br>Acute complicated injury ❑ | Physiologic tests under stress<br>Dx endoscopies NO risk factors<br>Deep needle or incisional bx<br>CV imaging + contrast<br>Obtain fluid from body cavity ❑ | Minor surgery + risk factors<br>Elective major surgery<br>Prescription drug therapy<br>Therapeutic nuclear medicine<br>IV fluids + additives ❑ |
| ***High*** ❑ | Sev exac, ≥1 chron prob<br>Acute or chronic illness posing threat to life/limb<br>Abrupt change neuro status ❑ | CV imaging + contrast, risk factors<br>Card electrophysiologic studies<br>Dx endoscopies + risk factors<br>Discography ❑ | Elective maj surg + risk factors<br>Emergency major surgery<br>Parenteral controlled sub<br>Rx requiring intense monitoring<br>DNR or de-escalation of care ❑ |

Check corresponding box below on Line C of **Final Result for Complexity of MDM**

**Final Result for Complexity of Medical Decision Making**

The column with 2 or 3 circles determines overall complexity of Medical Decision Making

| | | | | | |
|---|---|---|---|---|---|
| **A** | **Number Tx Options** *See TOTAL above in Box A* | ❑1 or less *Minimal* | ❑2 *Limited* | ❑3 *Multiple* | ❑4 *Extensive* |
| **B** | **Amount of Data** *See TOTAL above in Box B* | ❑1 or less *Minimal* | ❑2 *Limited* | ❑3 *Multiple* | ❑4 *Extensive* |
| **C** | **Highest Risk** *See Box C Above* | ❑*Minimal* | ❑*Low* | ❑*Moderate* | ❑*High* |
| | **Decision Making Level** | ❑**SF** | ❑**Low** | ❑**Moderate** | ❑**High** |

Patient
Facility

DOB
Encounter Date

MRN

**OVERALL OUTPATIENT ENCOUNTER LEVEL**

| | New Office / Consult / ER<br>Requires 3 components within shaded area | | | | | Established Office<br>Requires 2 components within shaded area | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| History | ❑PF<br>ER: PF | ❑EPF<br>ER: EPF | ❑D<br>ER: EPF | ❑C<br>ER: D | ❑C<br>ER: C | Minimal problem that may not require presence of physician | ❑PF | ❑EPF | ❑D | ❑C |
| Exam | ❑PF<br>ER: P | ❑EPF<br>ER: EPF | ❑D<br>ER: EPF | ❑C<br>ER: D | ❑C<br>ER: C | | ❑PF | ❑EPF | ❑D | ❑C |
| Complexity Medical Decision | ❑SF<br>ER: SF | ❑SF<br>ER: L | ❑L<br>ER: M | ❑M<br>ER: M | ❑H<br>ER: H | | ❑SF | ❑L | ❑M | ❑H |
| LEVEL | ❑I | ❑II | ❑III | ❑IV | ❑V | ❑I | ❑II | ❑III | ❑IV | ❑V |

PF = Prob focused EPF = Expanded prob focused D = Detailed C = Comprehensive
SF = Straightforward L = Low complexity M = Moderate complexity H = High complexity

**OVERALL INPATIENT ENCOUNTER LEVEL**

| | Initial Hosp Encounter or Observation | | | Subsequent Inpatient or Follow Up | | |
|---|---|---|---|---|---|---|
| History | ❑D or C | ❑C | ❑C | ❑PF | ❑EPF | ❑D |
| Exam | ❑D or C | ❑C | ❑C | ❑PF | ❑EPF | ❑D |
| Complexity Medical Decision | ❑SF / L | ❑M | ❑H | ❑SF / L | ❑M | ❑H |
| LEVEL | ❑I | ❑II | ❑III | ❑I | ❑II | ❑III |

PF = Prob focused EPF = Expanded prob focused D = Detailed C = Comprehensive
SF = Straightforward L = Low complexity M = Moderate complexity H = High complexity

**Time** *If ALL responses regarding time are "Yes", billing may be based on Time*

"If the physician documents total time *and* suggests that counseling or coordinating care dominates (more than 50%) the encounter, time may determine level of service. Documentation may refer to: prognosis, differential diagnosis, risks, benefits of treatment, instructions, compliance, risk reduction or discussion with another health care provider."

| | |
|---|---|
| Does documentation reveal total time? **Must be face-to-face (Outpatient or Inpatient)** | ❑Yes ❑No |
| Does documentation discuss the content of counseling or coordination of care? | ❑Yes ❑No |
| Does documentation reveal that more than half the time was spent on counseling or coordination of care? | ❑Yes ❑No |

**References**

1997 Guidelines for Evaluation and Management Services
http://www.cms.hhs.gov/MLNProducts/Downloads/MASTER1.pdf

HGSAdministrators Documentation Worksheet
www.aaco.com/advocacy/pdf/AUDITTOOLMEDICARE.pdf

Evaluation and Management Coding and Documentation Reference Guide

3

FREE Medical Documentation Tool brought to you by The Folks at MedicalTemplates
Also try ***E/M Code Check***, a great iPhone App for billing and coding, made by e-Medtools

# Case Studies

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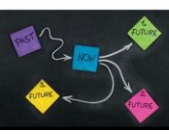

# Case #1

A 24-year-old male presents with a history of seafood allergy and we conduct an oral challenge to seafood. 70 minutes into the graded oral challenge, the patient has an anaphylactic reaction. We administer epinephrine, give an albuterol treatment and oxygen, performed spirometry and pulse ox, and gave a steroid injection and Benadryl injection. The treatment and monitoring took an additional 145 minutes. Total time for the visit is 215 minutes. What would be the proper way to bill this visit?




# Case #2

You started a new practice, and are just putting a patient on venom immunotherapy. Which codes do you use to bill out venom immunotherapy? How do you find out which codes to use and which is the most profitable to use: 95130-95134 or 95145-95149? What if the patient is allergic to all 5 stinging insects and fire ants, and the patient needs a total of 6 venom injections?

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# Case #3

An 18-year-old asthma patient presents for a routine injection of Xolair. He gets a spirometry. The nurse gets basic vital signs and a chief complaint and documents preparation of Xolair, and meets all of the E&M elements to bill a level 1 visit. Can we bill a level 1 visit and one of the injection codes and spirometry and drug?




# Case #4

A 12-year-old male patient with seasonal allergic rhinitis and asthma gets an allergy injection. He gets spirometry. The nurse gets basic vital signs and a chief complaint and documents the visit and meets all of the E&M requirements to bill a level 1 visit. Can we bill a level 1 visit and one of the injection codes and spirometry and drug?

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# Case #5

A patient presents for allergy testing. We applied 50 skin pricks, and they were all positive including the negative control. Because the positive control was negative, the physician decided that the testing was indeterminate. The patient then realizes that she took a “sleep medication” the night before. Can you bill out the 50 skin tests? How do you document this? How would you tell the patient about this?




# Alternative Case #5

A patient presents for allergy testing. We applied 50 skin pricks, and they were all positive including the negative control. Because the negative control was positive, the physician decided that the patient was dermatographic and that the testing was indeterminate. The patient is very frustrated with the results of the test. Can you bill out the 50 skin tests? How do you document this? How would you tell the patient about this?

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# Case #6

A 56-year-old patient with mildly uncontrolled moderate persistent asthma and allergic rhinitis presents to your office for a follow-up asthma visit. She has lots of trouble understanding and using her asthma medications, she wants to initiate immunotherapy and has a lot of questions. Total visit time was 70 minutes; during this time you do the following:

- The ACT test was administered during the 10 minutes she was waiting for the physician and the nurses were collecting all of the triage information
- The physician spent 30 minutes with the patient. 20 minutes were spent talking to the patient and getting H&P. 10 minutes were for prescription management, which included getting her a nebulizer and writing out an asthma action plan.
- The nurse spends 15 minutes demonstrating proper inhaler technique with the patient multiple times
- At the request of the physician, the nurse spends another 15 minutes discussing how immunotherapy is done at the office.

How do you document and bill all of the steps taken during this visit?
You will be seeing this patient frequently. What are all of the chronic disease management codes you can use?

# Case #7

A 65-year-old well established and very kind patient calls after hours at 11 pm for an acute sinus infection. The patient is on vacation and asks for an antibiotic. You are half asleep, and you decide to call the antibiotic in for the patient. Are there any new codes to bill this phone call? Can this be called a telemedicine visit?