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Maxine Collins, MBA, CPA, CMC, CMIS, CMOM

On the topic: E/M Chart Auditing Basics
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E/M Chart Auditing Basics

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JUST IN CASE YOU MISSED IT

CMS NEWS FOR 2019

CMS FINAL 2019 FEE SCHEDULE INFORMATION FOR
PHYSICIANS & ANESTHESIA

• Some good, some bad news in 2019:
  1. Conversion factor payment increase for Physicians up $ .0431 - Wow! ($ 36.0391 – up from $ 35.996)
  2. Conversion factor payment increase for Anesthesia up $ .0843 – Not much better! ($ 22.2730 – up from $ 22.1887)
  3. Evaluation and Management Documentation changes:
     • Physicians no longer required to re-record elements of history and physical exam when there is evidence that he/she reviewed and updated.
     • Physicians can now only document that they reviewed and verified information regarding chief complaint and history that has already been recorded by ancillary staff or the patient.
     • Warning – these changes apply only to Medicare patients. It remains to be seen how other carriers will follow.
  4. CMS did not finalize rules proposed to reduce the payment when an office visit was performed on the same day as another service. This is still being considered for future proposals.
5. CMS did not go forward in 2019 (postponing until 2021) with the proposed single payment rate for office/outpatient visits Levels 2 thru 5.
   • Instead proposing for 2021 to collapse Levels 2 thru 4 into a single payment and maintaining Level 5 for more complex patients. (Then they will have control of price!)

6. For CYs 2019 and 2020:
   – CMS will continue the current coding and payment structure for E/M office/outpatient visits; and
   – Practitioners should continue to use either the 1995 or 1997 E/M documentation guidelines to document E/M office/outpatient visits bill to Medicare.

Source: www.cms.gov
MODERNIZING MEDICARE PHYSICIAN PAYMENT

• CMS finalized its proposals to pay separately for two newly defined physicians' services furnished using communication technology:
  – Brief communication technology-based service:
    • Example – virtual check-in (HCPCS code G2012)
  – Remote evaluation of recorded video and/or images submitted by an established patient (HCPCS code G2010).

• CMS also finalized policies to pay separately for new coding describing chronic care remote physiologic monitoring:
  – CPT codes 99453, 99454, and 99457; and

• Interprofessional internet consultation
  – CPT codes 99451, 99452, 99446, 99447, 99448, and 99499.

NEW MEDICARE HCPCS CODES FOR 2019

• G2010 - Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment
  – RVU/Reimbursement – Non-Facility - 0.35; Medicare Allowable - $ 12.61 (National)
    Facility 0.25; Medicare Allowable - $ 9.14

• G2012 - Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion
  – RVU – Non-Facility - 0.401; Medicare Allowable - $ 14.78 (National)
  – RVU – Facility - 0.36 ; $ 12.96
NEW MEDICARE HCPCS CODE(S) FOR 2019

- **G2011** - Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., audit, dast), and brief intervention, 5-14 minutes
  - RVU – Non-Facility & Facility - 0.46; Medicare Allowable - $ 16.52 (National)

EXPANDING USE OF TELEHEALTH SERVICES FOR TREATMENT OF OPIOID USE DISORDER

- Through an interim final rule with comment period, CMS is implementing a provision from the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act that:
  - Removes the originating site geographic requirements; and
  - Adds the home of an individual as a permissible originating site for telehealth services furnished for purposes of treatment of a substance use disorder or a co-occurring mental health disorder for services furnished on or after July 1, 2019
INTER-PROFESSIONAL CONSULTATIONS

- **Two new codes and separate payment for:**
  - Inter-professional internet/telephone consultations between a treating physician and a consulting physician:
    - **CPT code 99451** - Interprofessional telephone/internet/electronic health record assessment and management service provided by a consultative physician, including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 minutes or more of medical consultative time.
      - RVU – Facility and Non-Facility - 1.01; Reimbursement $36.47.
    - **CPT code 99452** - Interprofessional telephone/internet/electronic health record referral service(s) provided by a treating/requesting physician or other qualified health care professional, 30 minutes.
      - RVU – Facility and Non-Facility - 1.01; Reimbursement $36.47.

AMA© Guidelines

- **The consultant should use codes:**
  - 99446, 99447, 99448, 99449, 99451
    - To report interprofessional telephone/internet/electronic health record consultations.
    - An interprofessional telephone/internet/electronic health record consultation is an assessment and management service in which a patient's treating (eg, attending or primary) physician or other qualified health care professional requests the opinion and/or treatment advice of a physician with specific specialty expertise (the consultant) to assist the treating physician or other qualified health care professional in the diagnosis and/or management of the patient's problem without patient face-to-face contact with the consultant.

AMA© Guidelines

• The patient for whom the interprofessional telephone/Internet/electronic health record consultation is requested may be:
  – Either a new patient to the consultant;
  – Or an established patient with a new problem or an exacerbation of an existing problem.
  – However, the consultant should not have seen the patient in a face-to-face encounter within the last 14 days.
  – When the telephone/Internet/electronic health record consultation leads to a transfer of care or other face-to-face service (eg, a surgery, a hospital visit, or a scheduled office evaluation of the patient) within the next 14 days or next available appointment date of the consultant, these codes are not reported.


AMA© Guidelines

• When reporting 99446 (RVU 0.497), 99447 (RVU 0.985), 99448 (RVU 1.482), 99449 (RVU 1.97), 99451 (RVU 1.012):
  – Review of:
    • pertinent medical records,
    • laboratory studies,
    • imaging studies,
    • medication profile,
    • pathology specimens, etc.
    is included in the telephone/Internet/electronic health record consultation service and should not be reported separately.
  – The majority of the service time reported (greater than 50%) must be devoted to the medical consultative verbal or Internet discussion.
  – If greater than 50% of the time for the service is devoted to data review and/or analysis, 99446, 99447, 99448, 99449 should not be reported.
  – However, the service time for 99451 is based on total review and interprofessional-communication time.

*Using Novitas RVUs.

AMA© Guidelines

• If more than one telephone/Internet/electronic health record contact(s) is required to complete the consultation request (eg, discussion of test results), the entirety of the service and the cumulative discussion and information review time should be reported with a single code.

• Codes 99446, 99447, 99448, 99449, 99451 should not be reported more than once within a seven-day interval.

• The written or verbal request for telephone/Internet/ electronic health record advice by the treating/requesting physician or other qualified health care professional should be documented in the patient’s medical record, including the reason for the request.

• Codes 99446, 99447, 99448, 99449 conclude with a verbal opinion report and written report from the consultant to the treating/requesting physician or other qualified health care professional.

• Code 99451 concludes with only a written report.


REMOTE PATIENT MONITORING

• Three new Chronic Care remote physiologic monitoring codes effective 01/01/2019:
  1. CPT 99453 - Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment. RVU Facility or Non-Facility - 0.51. AMA Guidelines: (Do not report 99453 more than once per episode of care)
     • (Do not report 99453 for monitoring of less than 16 days)

  2. CPT 99454 - Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days. RVU – Facility or Non-Facility - 1.67. AMA Guidelines: (For physiologic monitoring treatment management services, use 99457)
     • (Do not report 99454 for monitoring of less than 16 days)
     • (Do not report 99453, 99454 in conjunction with codes for more specific physiologic parameters [eg, 93296, 94760])

  3. CPT 99457 - Remote physiologic monitoring treatment management services, 20 minutes or more of clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month. RVU Facility - 0.68; Non-Facility - 1.37. AMA Guidelines: (Report 99457 once each 30 days, regardless of the number of parameters monitored)
     • (Do not report 99457 in conjunction with 99091)
TWO NEW TELEHEALTH CPT CODES FOR PROLONGED PREVENTIVE SERVICES

• These qualify as “Medicare telehealth services” and must use the telehealth place of service (POS) code “02”.
  – G0513 - Prolonged preventive service(s) *(beyond the typical service time of the primary procedure)*, in the office or other outpatient setting requiring direct patient contact beyond the usual service; first 30 minutes (list separately in addition to code for preventive service).
    • RVU – Facility - 1.68; Non-Facility - 1.78.
  – G0514 - Prolonged preventive service(s) *(beyond the typical service time of the primary procedure)*, in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes (list separately in addition to code G0513 for additional 30 minutes of preventive service).
    • RVU – Facility – 1.68; Non-Facility – 1.78.

CHANGES TO OUTPATIENT THERAPY

• CMS finalized its proposal to discontinue the functional status reporting requirements for services furnished after January 1, 2019.
• In addition, The Bipartisan Budget Act of 2018 requires payment for services furnished in whole or in part by a therapy assistant at 85% of the applicable Part B payment amount for service effective January 1, 2022.
  – In order to implement this payment reduction, the law required CMS to establish a new modifier by January 1, 2019 and CMS to detail its plans to accomplish this in the final rule.
  – Two New modifiers have been finalized:
    • one for Physical Therapy Assistants (PTA); and
    • another for Occupational Therapy Assistants (OTA)
  – When services are furnished in whole or in part by a PTA or OTA:
    • However, CMS finalized the new modifiers as “payment” rather than as “therapy” modifiers, based on comments by stakeholders.
    • These will be used alongside of the current PT and OT modifiers to report all PT, OT, and Speech Language Pathology (SLP) services, that have been used since 1998 to track outpatient therapy services that were subject to therapy caps.
  – CMS also finalized a de minimis standard under which a service is furnished by the PTA or OTA, instead of the proposed definition that applied when a PTA or OTA furnished any minute of a therapeutic service.
    • The new therapy modifiers for services furnished by PTAs and OTAs are not required on claims until January 1, 2020.
Introduction

• The Medical record:
  – *A legal document* that serves as a chronological record of pertinent facts and observations about a patient’s health.

• A chart audit is:
  – *An examination of medical records* to determine how well a practice performs.

• The Office of Inspector General (OIG) has:
  – *Initiated audit initiatives to determine whether Medicare is making erroneous payments.*
  – A “*baseline audit*” should be conducted to examine the claim development and submission process and to develop and/or amend the written “*7-Step Compliance Program*” as published in the Federal Register in October, 2000.
THE SEVEN FUNDAMENTAL ELEMENTS OF A COMPLIANCE PROGRAM

1. **Written** plan with policies and procedures
2. Designation of a **compliance professional or officer** to oversee the plan.
3. **Effective training** provided to all staff, employees, and physicians/providers.
4. **Effective communication** – an “open door policy” for reporting compliance concerns.
5. **Internal monitoring** with chart auditing.
6. **Enforcement** of the standards.
7. **Prompt response** to address and document any and all compliance issues identified.
OIG GUIDANCE

- Fraud Prevention and Detection Guidelines from the OIG:
  - Compliance Program Guidance
  - Fraud Alerts, Special Advisory Bulletin and other Guidance
  - Advisory Opinions
- Tips from the OIG:
  1. Make compliance plans a priority now!
  2. Know your fraud and abuse risk areas
     - How? – Have a “base-line audit” performed
     - Provides guidance on structuring the entire compliance program
  3. Become knowledgeable and manage appropriately your financial relationships.
  4. “Just because your competitor is doing something doesn’t mean you can or should”.
  5. When in doubt, research, investigate and ask for help.

What Causes a Carrier Audit?

- Random audits
- Complaints from patients and employees
- Repeated billing problems from carrier
- Abnormal distribution of E/M levels of care
- Unusually high numbers of any single code
- Failure to follow non-par Medicare rules
- Failure to routinely collect deductibles and co-pays
- Medical record that does not support the CPT® code
MEDICAL NECESSITY

- E/M services must be medically reasonable and necessary, in addition to meeting the individual requirements of the CPT® code that is used on the claim.

- According to CMS, "Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted."

- Physicians are responsible for ensuring that the claims they submit to Medicare accurately reflect the E/M services provided and the billing levels corresponding to those services.
Fighting Fraud in HHS Programs

Highlights - Enforcement Accomplishments in 2018:
• OIG remains at the forefront of the Nation’s efforts to fight fraud in HHS programs and hold wrongdoers accountable for their actions.
• Fraud increases not only HHS costs, but also risk and potential harm to beneficiaries.
• During FY 2018, OIG reported the following:
  – Expected investigative recoveries of $2.91 billion
  – Criminal actions against 764 individuals or entities that engaged in crimes against HHS programs
  – Exclusion of 2,712 individuals and entities from Federal healthcare programs
  – Civil actions against 813 individuals or entities


Audit Surveillance Increasing

• The Office of the Inspector General is increasing its audit surveillance.

• New attention from the OIG, RACs, ZPICs, PSCs are resulting in medical offices losing thousands of dollars annually.
Types of Audits

- There are many types of medical record audits:
  - Internal audits
  - Preliminary audits
  - Comprehensive audits
  - Retrospective audits
  - Pre-payment audits
  - Compliance audits
  - External audits

The fiscal year (FY) 2018 Medicare FFS program improper payment rate is 8.12 percent, representing $31.62 billion in improper payments, compared to the FY 2017 improper payment rate of 9.51 percent or $36.21 billion in improper payments (1).

The table below outlines the improper payment rate and projected improper payment amount by claim type for FY 2018.

<table>
<thead>
<tr>
<th>Claim Type</th>
<th>Improper Payment Rate</th>
<th>Improper Payment Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>8.12%</td>
<td>$31.62 B</td>
</tr>
<tr>
<td>Part A Providers (excluding Hospital Inpatient Prospective Payment System (IPPS))</td>
<td>8.07%</td>
<td>$13.60 B</td>
</tr>
<tr>
<td><strong>Part B Providers</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital IPPS</td>
<td>10.68%</td>
<td>$10.47 B</td>
</tr>
<tr>
<td>Durable Medical Equipment, Prosthetics, Orthotics, and Supplies</td>
<td>35.54%</td>
<td>$2.59 B</td>
</tr>
</tbody>
</table>
### 2017 A/B MAC Jurisdictions

<table>
<thead>
<tr>
<th>MAC Jurisdiction</th>
<th>2017 Improper Payment Rate</th>
<th>% of Total 2017 Medicare FFS Improper Payments</th>
<th>Error Rate Contribution Score Label</th>
<th>% of Total 2017 Medicare FFS Expenditures</th>
</tr>
</thead>
<tbody>
<tr>
<td>RRB</td>
<td>10.5%</td>
<td>0.2%</td>
<td>Low (0-8)</td>
<td>0.2%</td>
</tr>
<tr>
<td>J5</td>
<td>7.8%</td>
<td>5.4%</td>
<td>Low (0-8)</td>
<td>6.7%</td>
</tr>
<tr>
<td>J6</td>
<td>3.4%</td>
<td>1.9%</td>
<td>Low (0-8)</td>
<td>5.6%</td>
</tr>
<tr>
<td>J8</td>
<td>7.0%</td>
<td>2.8%</td>
<td>Low (0-8)</td>
<td>3.9%</td>
</tr>
<tr>
<td>JE</td>
<td>7.0%</td>
<td>6.4%</td>
<td>Low (0-8)</td>
<td>8.1%</td>
</tr>
<tr>
<td>JF</td>
<td>7.2%</td>
<td>3.4%</td>
<td>Low (0-8)</td>
<td>4.5%</td>
</tr>
<tr>
<td>JH</td>
<td>7.7%</td>
<td>8.7%</td>
<td>Low (0-8)</td>
<td>10.8%</td>
</tr>
<tr>
<td>JJ</td>
<td>10.1%</td>
<td>5.7%</td>
<td>Low (0-8)</td>
<td>5.4%</td>
</tr>
<tr>
<td>JK</td>
<td>2.8%</td>
<td>2.8%</td>
<td>Low (0-8)</td>
<td>9.5%</td>
</tr>
<tr>
<td>JL</td>
<td>6.0%</td>
<td>6.5%</td>
<td>Low (0-8)</td>
<td>9.5%</td>
</tr>
<tr>
<td>JM</td>
<td>7.9%</td>
<td>4.4%</td>
<td>Low (0-8)</td>
<td>5.3%</td>
</tr>
<tr>
<td>JN</td>
<td>6.3%</td>
<td>3.1%</td>
<td>Low (0-8)</td>
<td>4.7%</td>
</tr>
<tr>
<td>J15</td>
<td>15.9%</td>
<td>6.6%</td>
<td>Medium (9-15)</td>
<td>4.0%</td>
</tr>
</tbody>
</table>

RRB – Railroad Benefit MAC  
JH - Novitas  
JJ - Palmetto  
J15 - CGS

### E/M UTILIZATION BENCHMARKING TOOL – AAPC


2016 DATA
IMPROPER DOCUMENTATION AND CODING

Tennessee Nurse Agrees to 10 Year Exclusion

- On September 14, 2018, Cindy Scott, R.N., A.P.R.N. (Scott), Tennessee, agreed to be excluded from participation in all Federal health care programs for a period of ten years under 42 U.S.C. §§ 1320a-7(b)(6)(B) and 1320a-7(b)(7).
- OIG alleged Scott submitted or caused the submission of false claims for controlled substance prescriptions that were medically unnecessary, substantially in excess of the needs of her patients, and below the professionally recognized standards of care.
- Specifically, OIG alleged Scott prescribed monthly prescriptions to individual patients exceeding a daily dosage of five hundred (500) morphine milligram equivalents (MME), which included inappropriate combinations of long and short acting opioids often combined with high amounts of a benzodiazepine and/or carisoprodol.
- OIG also alleged Scott prescribed controlled substances and combinations of controlled substances and other medication without appropriately documenting:
  1. a clear objective finding of a chronic pain source to justify the ongoing and increasing prescribing;
  2. attempts to identify the etiology of reported pain;
  3. a thorough history or adequately inquiring into potential substance abuse history; or
  4. a written treatment plan with regard to the use of the prescriptions.
- Senior Counsels Andrea Treese Berlin, Katie Fink, and Joan Matlack represented OIG.
Arizona Physician Settles Case Involving Kickback and Stark Allegations

- **10-03-2018**
  On October 3, 2018, Ronald Burns, M.D. (Dr. Burns), Phoenix, Arizona, entered into a $75,409.15 settlement agreement with OIG.
- The settlement agreement resolves allegations that Dr. Burns, in his capacity as then owner of a pain management practice, entered into contracts on behalf of the pain management practice and received remuneration from Millennium Health, LLC f/k/a Millennium Laboratories, Inc. (Millennium), in the form of point of care test cups which resulted in prohibited referrals.
- OIG further alleged that the referrals were prohibited because the remuneration created a financial relationship and that Dr. Burns caused Millennium to present claims for designated health services that resulted from the prohibited referrals.
- Senior Counsels Andrea Treese Berlin and Geoffrey Hymans represented OIG.

What Can Your Healthcare Organization Do to Avoid Audits?

1. Ensure your practice has a WRITTEN compliance program.
2. Ensure that your practice has a Billing Policy Manual.
3. Ensure that your healthcare organization conducts periodic chart audits internally.
4. Attend education sessions for the entire office on a regular basis.
5. A billing service should be investigated thoroughly prior to hiring.
6. Use only CURRENT ICD-10 and CPT® coding books.
7. Develop/Use forms and checklists to eliminate human error.
8. New providers hired should be trained on documentation guidelines.
DOCUMENTATION GUIDELINES FOR EVALUATION/MANAGEMENT SERVICES

General Principles of Medical Record Documentation

The principles of documentation listed below are applicable to all types of medical and surgical services in all settings. For Evaluation and Management (E/M) services, the nature and amount of physician work and documentation varies by type of service, place of service and the patient’s status. The general principles listed below may be modified to account for these variable circumstances in providing E/M services:

1. The medical record should be complete and legible.

2. The documentation of each patient encounter should include:
   - reason for the encounter and relevant history, physical examination findings and prior diagnostic test results;
   - assessment, clinical impression or diagnosis;
   - plan for care;
   - date and legible identity of the observer.
General Principles of Medical Record Documentation

3. If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.

4. Past and present diagnoses should be accessible to the treating and/or consulting physician.

5. Appropriate health risk factors should be identified.

6. The patient's progress, response to and changes in treatment, as well as revision of diagnosis should be documented.

7. The CPT® and ICD-10 codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.

Documentation of E/M Services

The descriptors for the levels of E/M services recognized seven components that are used in defining the levels of E/M services. These components are:

- history
- examination
- medical decision making
- counseling
- coordination of care
- nature of presenting problem; and
- time
HISTORY – THE THREE KEY COMPONENTS

- The first three of these components are the key components in selecting the level of E/M services:
  1. history,
  2. examination, and
  3. medical decision making

- Because the level of E/M service is dependent on all three key components, performance, and documentation of one component at the highest level does not necessarily mean that the encounter in its entirety qualifies for the highest level of E/M service.
- These documentation guidelines for E/M services reflect the needs of the typical adult population.

Documentation of E/M Services

Documentation of History – First Key Component:

- The levels of E/M services are based on four types of history (Problem Focused, Expanded Problem Focused, Detailed, and Comprehensive). Each type of history includes some or all of the following elements:
  - Chief complaint (CC); (Required for all types of history)
  - Three elements of the History Component;
    - History of present illness (HPI);
    - Review of systems (ROS); and
    - Past, family and/or social history (PFSH).

- The extent of history of present illness, review of systems and past, family and/or social history that is obtained and documented is dependent upon clinical judgment and the nature of the presenting problem(s).
### Capsulization of History Documentation Requirements

<table>
<thead>
<tr>
<th>Chief Complaint</th>
<th>History of Present Illness</th>
<th>Review of Systems</th>
<th>Past, Family and/or Social History</th>
<th>Type of History</th>
</tr>
</thead>
<tbody>
<tr>
<td>V</td>
<td>Brief (1-3)</td>
<td>N/A</td>
<td>N/A</td>
<td>Problem Focused</td>
</tr>
<tr>
<td>V</td>
<td>Brief (1-3)</td>
<td>Problem Pertinent</td>
<td>N/A</td>
<td>Extended</td>
</tr>
<tr>
<td>V</td>
<td>Extended (4+)*</td>
<td>Extended (2-9)</td>
<td>Pertinent (1 of 3)</td>
<td>Detailed</td>
</tr>
<tr>
<td>V</td>
<td>Extended (4+)*</td>
<td>Complete (10+)</td>
<td>Complete (2 of 3) or (3 of 3)**</td>
<td>Comprehensive</td>
</tr>
</tbody>
</table>

*Status of 3 chronic of inactive conditions

**2 of 3 is for an established patient; 3 of 3 is for a new patient

---

- **DG:** The **CC, ROS and PFSH** may be listed as separate elements of history, or they may be included in the description of the history of the present illness.

- **DG:** A **ROS and/or a PFSH obtained during an earlier encounter does not need to be re-recorded if there is evidence that the physician reviewed and updated the previous information. The review and update may be documented by:**
  - Describing any new **ROS and/or PFSH information** or noting there has been no change in the information; and
  - Noting the **date and location of the earlier ROS and/or PFSH**.

- There are changes in this area for 2018 documentation depending on the guidelines being followed.
• **DG:** The ROS and/or PFSH may be recorded by ancillary staff or on a form completed by the patient. There must be a notation supplementing or confirming the information recorded by others.

• **DG:** If the physician is unable to obtain a history from the patient or other source, the record should describe the patient’s condition or other circumstance which precludes obtaining a history.

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**Chief Complaint**

Chief complaint (CC) (Required)

• 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, usually stated in the patient’s words.

• **DG:** The medical record should clearly reflect the chief complaint.
**History of Present Illness (HPI)**

- The HPI is a chronological description of the development of the patient's present illness from the first sign and/or symptom or from the previous encounter to the present. It includes the following elements:
  - location,
  - quality,
  - severity,
  - duration,
  - timing,
  - context,
  - modifying factors, and
  - associated signs and symptoms.

- **Brief** and extended HPIs are distinguished by the amount of detail needed to accurately characterize the clinical problem(s).

- A **brief** HPI consists of **one to three elements of the HPI**.
  
  **DG:** The medical record should describe one to three elements of the present illness (HPI).

- An **extended** HPI consists of at least **four elements of the HPI or the status of at least three chronic or inactive conditions**.
  
  **DG:** The medical record should describe at least four or more elements of the present illness (HPI) or status of at least three chronic or inactive conditions.
### Review of Systems (ROS)

A ROS is an inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms which the patient may be experiencing or has experienced. For purposes of ROS, the following systems are recognized:

- Constitutional symptoms (fever, weight loss)
- Eyes
- Ears, Nose, Mouth, Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary (skin and/or breast)
- Neurological
- Psychiatric
- Endocrine
- Hematologic/Lymphatic
- Allergic/Immunologic

### Problem Pertinent ROS

- A **problem pertinent** ROS inquires about the system directly related to the problem(s) identified in the HPI.

  - **DG:** The patient’s positive responses and pertinent negatives for the system related to the problem should be documented.

- An **extended** ROS inquires about the system directly related to the problem(s) identified in the HPI and a limited number of additional systems.

  - **DG:** The patient’s positive responses and pertinent negatives for two to nine systems should be documented.
Complete ROS

• A complete ROS inquires about the system(s) directly related to the problem(s) identified in the HPI plus all additional body systems.

**DG:** At least 10 organ systems must be reviewed. Those systems with positive or pertinent negative responses must be individually documented. For the remaining systems, a notation indicating all other systems are negative is permissible. In the absence of such a notation, at least 10 systems must be individually documented.

Past, Family and/or Social History (PFSH)

The PFSH consists of a review of three areas:

• 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 which may be hereditary or place the patient at risk);

• social history (an age-appropriate review of past and current activities).
Pertinent PFSH

A *pertinent* PFSH is of a review of the history area(s) directly related to the problem(s) identified in the HPI.

**DG:** At least one specific item from *any* of the three history areas must be documented for a pertinent PFSH.

---

Complete PFSH

A *complete* PFSH is of a review of two or all three of the PFSH history areas, depending on the category of the E/M service. A review of all three history areas is required for services that by their nature include a comprehensive assessment or reassessment of the patient. A review of two of the three history areas is sufficient for other services.

**DG:** At least one specific item from *two* of the three history areas must be documented for a complete PFSH for the following E/M services: office or other outpatient services, established patient; emergency department; subsequent nursing facility care; domiciliary care, established patient; and home care, established patient.
Past History

A review of the patient's past experiences with illnesses, injuries, and treatments that include significant information about:

- prior major illnesses and injuries
- prior operations
- prior hospitalizations
- current medications
- allergies
- age appropriate immunizations
- age appropriate feeding/dietary status

Family History

A review of medical events in the patient's family that includes significant information about:

- the health status or cause of death of parents, siblings, and children
- specific diseases related to problems identified in the chief complaint or history of the present illness and/or review of systems
- diseases of family members which may be hereditary or place the patient at risk
Social History

An age-appropriate review of past and current activities which include significant information about:

- marital status and/or living arrangements
- current employment
- occupational history
- use of drugs, alcohol, and tobacco
- level of education
- sexual history
- other relevant social factors

Documentation of Examination

The levels of E/M services are based on four types of examination that are defined as follows:

- **Problem Focused** -- a limited examination of the affected body area or organ system.
- **Expanded Problem Focused** -- a limited examination of the affected body area or organ system and any other symptomatic or related body area(s) or organ system(s).
- **Detailed** -- an extended examination of the affected body area(s) or organ system(s) and any other symptomatic or related body area(s) or organ system(s).
- **Comprehensive** -- a general multi-system examination or complete examination of a single organ system and other symptomatic or related body area(s) or organ system(s).
Types of Examinations

These types of examinations have been defined for general multi-system and the following single organ systems:

- Cardiovascular
- Ears, Nose, Mouth and Throat
- Eyes
- Genitourinary (Female)
- Genitourinary (Male)
- Hematologic/Lymphatic/Immunologic
- Musculoskeletal
- Neurological*
- Psychiatric
- Respiratory
- Skin*

*dependent on a demonstration that the physician work is equivalent to that of a general multi-system examination

General Multi-System Examinations

A general multi-system examination or a single organ system examination may be performed by any physician regardless of specialty.

To qualify for a given level of multi-system examination, the following content and documentation requirements should be met:

- **Problem Focused Examination** – should include performance and documentation of **one to five elements in one or more organ systems(s) or body area(s).**
- **Expanded Problem Focused Examination** – should include performance and documentation of **at least six elements in one or more related body area(s) or organ system(s).**
- **Detailed Examination** – should include **at least six organ systems or body areas** with a least two elements, for a total of **twelve elements.**
- **Comprehensive** – should include **at least nine organ system or body areas.** For each area/system, documentation of **at least two elements.**
General Multi-System Exam

- Constitutional
- Eyes
- Ears, Nose, Mouth, and Throat
- Neck
- Respiratory
- Cardiovascular
- Chest (Breasts)
- Gastrointestinal
- Genitourinary
- Lymphatic
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric

Content and Documentation Requirements – General Multi-System Exam

<table>
<thead>
<tr>
<th>Level of Exam</th>
<th>Perform and Document</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem Focused</td>
<td>One to five elements identified by a bullet.</td>
</tr>
<tr>
<td>Expanded Problem Focused</td>
<td>At least six elements identified by a bullet.</td>
</tr>
<tr>
<td>Detailed</td>
<td>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.</td>
</tr>
<tr>
<td>Comprehensive</td>
<td>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 area/systems.</td>
</tr>
</tbody>
</table>
Documentation of the Complexity of Medical Decision Making

- Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by:
  - The number of possible diagnoses and/or the number of management options that must be considered.
  - The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed.
  - The risk of significant complications, morbidity, and/or mortality, as well as co-morbidities, associated with the patient’s presenting problem(s), the diagnostic procedure(s) and/or the possible management options.

<table>
<thead>
<tr>
<th>Number of Diagnoses or Management Options</th>
<th>Amount and/or Complexity of Data to be Reviewed</th>
<th>Risk of Significant Complications, Morbidity, and/or Mortality</th>
<th>Type of Decision Making*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>Minimal or None</td>
<td>Minimal</td>
<td>Straightforward</td>
</tr>
<tr>
<td>Limited</td>
<td>Limited</td>
<td>Low</td>
<td>Low Complexity</td>
</tr>
<tr>
<td>Multiple</td>
<td>Moderate</td>
<td>Moderate</td>
<td>Moderate Complexity</td>
</tr>
<tr>
<td>Extensive</td>
<td>Extensive</td>
<td>High</td>
<td>High Complexity</td>
</tr>
</tbody>
</table>

*NOTE – to qualify for a type of medical decision making, 2 of 3 elements must either be met or exceeded.
Number of Diagnoses or Management Options

- The number of possible diagnoses and/or the number of management options that must be considered is based on the number and types of problems addressed during the encounter, the complexity of establishing a diagnosis and the management decisions that are made by the physician.
  - DG: For each encounter as assessment, clinical impression, or diagnosis should be documented.
  - DG: The initiation of, or changes in, treatment should be documented.
  - DG: If referrals are made, consultations requested or advice

Amount and/or Complexity of Data to be Reviewed

- Based on the types of diagnostic testing ordered or reviewed.
  - DG: If a diagnostic service is ordered, planned, scheduled, or performed at the time of the E/M encounter, the type of service should be documented.
  - DG: The review of lab, radiology, and/or other diagnostic tests should be documented.
  - DG: A decision to obtain old records or additional history from the family, caretaker, or other source to supplement that obtained from the patient should be documented.
  - DG: Relevant findings from the review of old records, and/or the receipt of additional history of family, caretaker, or other source should be documented.
Amount and/or Complexity of Data to be Reviewed

- **DG:** The results of discussion of laboratory, radiology or other diagnostic tests with the physician who performed or interpreted the study should be documented.

- **DG:** The direct visualization and independent interpretation of an image, tracing or specimen previously or subsequently interpreted by another physician should be documented.

Risk of Significant Complications, Morbidity, and/or Mortality

- Based on the risks associated with the presenting problem(s), the diagnostic procedures(s), and the possible management options.
  
  - **DG:** Co-morbidities/underlying diseases or other factors that increase the complexity of medical decision making by increasing the risk of complications, morbidity, and/or mortality should be documented.
  
  - **DG:** If a surgical or invasive diagnostic procedure is ordered, planned or scheduled at the time of the E/M encounter, the type of procedure should be documented.
  
  - **DG:** If a surgical or invasive diagnostic procedure is performed at the time of the E/M encounter, the specific procedure should be documented.
Risk of Significant Complications, Morbidity, and/or Mortality

• **DG:** The referral for or decision to perform a surgical or invasive diagnostic procedure on an urgent basis should be documented or implied.

<table>
<thead>
<tr>
<th>Minimal</th>
<th>Low</th>
<th>Moderate</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>• One self limited or minor problem, e.g. cold, insect bite</td>
<td>• Two or more self-limited or minor problems</td>
<td>• One or more chronic illness with mild exacerbation</td>
<td>• One or more chronic illnesses with severe exacerbation</td>
</tr>
<tr>
<td></td>
<td>• One stable, e.g. well controlled hypertension or diabetes</td>
<td>• Two or more stable chronic illnesses</td>
<td>• Acute or chronic illnesses or injuries that pose a threat to life of bodily function, e.g. multiple trauma, acute MI</td>
</tr>
<tr>
<td></td>
<td>• Acute uncomplicated illness or injury, e.g. cystitis, allergic rhinitis, simple sprain</td>
<td>• Undiagnosed new problem with uncertain prognosis, e.g. lump in breast, rectal bleeding</td>
<td>• Severe respiratory distress</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Acute illness with systemic symptoms, e.g. pyelonephritis, pneumonitis, colitis</td>
<td>• Progressive, severe rheumatoid arthritis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Acute complicated injury, e.g. head injury with brief loss of consciousness</td>
<td>• Depression with suicidal ideation</td>
</tr>
</tbody>
</table>
### Table 2 – DIAGNOSTIC PROCEDURES

<table>
<thead>
<tr>
<th>Minimal</th>
<th>Low</th>
<th>Moderate</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Lab tests requiring venipuncture&lt;br&gt;• Chest X-rays&lt;br&gt;• EKG&lt;br&gt;• EEG&lt;br&gt;• Urinalysis&lt;br&gt;• Ultrasound, e.g. echocardiography</td>
<td>• Physiologic tests not under stress, e.g. pulmonary function tests&lt;br&gt;• Non-cardiovascular imagine studies with contrast e.g. barium enema&lt;br&gt;• Superficial needle biopsies&lt;br&gt;• Clinical lab tests requiring arterial puncture</td>
<td>• Physiologic tests under stress, e.g. cardiac stress test&lt;br&gt;• Endoscopies with no identified risk factors&lt;br&gt;• Deep needle or incisional biopsy&lt;br&gt;• Cardiovascular imagining studies with contrast and no identified risk factors; e.g. arteriogram, cardiac catheterization&lt;br&gt;• Lumbar puncture</td>
<td>• Cardiovascular imaging studies with identified risk factors&lt;br&gt;• Cardiac electro physiological tests&lt;br&gt;• Endoscopies with identified risk factors</td>
</tr>
</tbody>
</table>

### Table 3 – MANAGEMENT OPTIONS

<table>
<thead>
<tr>
<th>Minimal</th>
<th>Low</th>
<th>Moderate</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Rest&lt;br&gt;• Gargles&lt;br&gt;• Elastic bandages&lt;br&gt;• Superficial dressings</td>
<td>• Over the counter drugs&lt;br&gt;• Minor surgery with no identified risk factors&lt;br&gt;• Physical Therapy&lt;br&gt;• Occupational therapy</td>
<td>• Minor surgery with identified risk factors&lt;br&gt;• Referral for or decision to perform elective major surgery with no identified risk factors&lt;br&gt;• Simple prescription drug management&lt;br&gt;• Therapeutic nuclear medicine</td>
<td>• Elective major surgery with identified risk factors&lt;br&gt;• Referral for or decision to perform emergency major surgery&lt;br&gt;• Parenteral controlled substances&lt;br&gt;• Multiple drug therapy requiring intensive monitoring for toxicity</td>
</tr>
</tbody>
</table>
Table 4 – In the table below, find the circle(s) farthest to the right. Draw a line down that column to the bottom row and circle to overall risk.

<table>
<thead>
<tr>
<th>Presenting Problem(s) (Table 1)</th>
<th>Minimal</th>
<th>Low</th>
<th>Moderate</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic Procedures (Table 2)</td>
<td>Minimal</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
</tr>
<tr>
<td>Management Options (Table 3)</td>
<td>Minimal</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
</tr>
<tr>
<td>Overall Risk</td>
<td>1 Minimal</td>
<td>2 Low</td>
<td>3 Moderate</td>
<td>4 High</td>
</tr>
</tbody>
</table>

1 2 3 4

[Table image]
**E&M Documentation Auditor’s Instructions**

Refer to data section (table below) in order to quantify. After referring to data, circle the entry farthest to the right in the table, which best describes the HPI, ROS and PPHR. If one column contains three dashes, draw a line down that column to the bottom row to identify the type of history. If no column contains three dashes, circle the column containing a dash farthest to the left, identifies the type of history.

<table>
<thead>
<tr>
<th>Type of History</th>
<th>Data of Statement in Table</th>
<th>Data of Statement in Table</th>
<th>Data of Statement in Table</th>
<th>Data of Statement in Table</th>
</tr>
</thead>
<tbody>
<tr>
<td>History</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PPHR</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HPI</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ROS</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SPP</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**HISTORY**

1. History of present illness: elements
   - Location
   - Sequence
   - Timing
   - Modifying factors

2. Family History
   - Exposed to familial history
   - Exposure to familial illness
   - Exposed to familial history
   - Exposure to familial illness

3. Social History
   - Occupation or work environment
   - Medical/surgical history
   - Allergies or medications

4. Personal史
   - Physical performance
   - Exercise or physical activity

5. Personal史
   - Personal illness
   - Personal treatment

**Complete ROS:** 1 or more systems or all the pertinent positive and negative of symptoms with a statement “all others negative.”

**Complete PPHR:** 2 history areas: a) Established Patients - Office (Outpatient) Care; b) Emergency Department.

3 history areas: a) New Patients - Office (Outpatient) Care, Doxiliary Care, Home Care; b) Initial Hospital Care.

**Complete PPHR:** Initial Hospital Observation; Initial Nursing Facility Care.

**NOTE:** For certain categories of E&M services that include only an oral history, it is not necessary to record information about the PPHR. Please refer to procedure code descriptions.

---

**1995 EXAM GUIDELINES WORKSHEET**

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 3.

<table>
<thead>
<tr>
<th>Limited to affected body area or organ systems (one body area or system related to problem)</th>
<th>PROBLEM FOCUSED EXAM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affected body area or organ systems and other symptomatic or related organ systems (additional systems up to total of 7)</td>
<td>EXPANDED PROBLEM FOCUSED EXAM</td>
</tr>
<tr>
<td>Extended exam of affected area(s) and other symptomatic or related organ system(s) (additional systems up to total of 7 or more depth than above)</td>
<td>DETAILED EXAM</td>
</tr>
<tr>
<td>General multi-system exam (8 or more systems) or complete exam of a single organ system</td>
<td>COMPREHENSIVE EXAM</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Body areas:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head, including face</td>
</tr>
<tr>
<td>Chest, including breasts and axilla</td>
</tr>
<tr>
<td>Abdomen</td>
</tr>
<tr>
<td>Neck</td>
</tr>
<tr>
<td>Back, including spine</td>
</tr>
<tr>
<td>Genitalia, penis, buttocks</td>
</tr>
<tr>
<td>Extremities</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Organ systems:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nervous system</td>
</tr>
<tr>
<td>Muscularkeletal system</td>
</tr>
<tr>
<td>Respiratory system</td>
</tr>
<tr>
<td>Cardiovascular system</td>
</tr>
<tr>
<td>Genitourinary system</td>
</tr>
<tr>
<td>Skin</td>
</tr>
<tr>
<td>Blood</td>
</tr>
<tr>
<td>Normal</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EXAM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Body area or system</td>
</tr>
<tr>
<td>1 body area or system</td>
</tr>
<tr>
<td>up to 7 systems</td>
</tr>
<tr>
<td>up to 7 systems</td>
</tr>
<tr>
<td>For more systems</td>
</tr>
</tbody>
</table>

---

75

76

38
### Level of Service

#### New Office, Outpatient, and Emergency Room

<table>
<thead>
<tr>
<th>Service</th>
<th>ER</th>
<th>OP</th>
<th>ER</th>
<th>OP</th>
</tr>
</thead>
<tbody>
<tr>
<td>History</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initial Hospital Observation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subsequent Hospital Observation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complexity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average time (minutes)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initial Nursing Facility</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subsequent Nursing Facility</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complexity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average time (minutes)</td>
<td></td>
<td></td>
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</tbody>
</table>

#### Nursing Facility Care

<table>
<thead>
<tr>
<th>Service</th>
<th>ER</th>
<th>OP</th>
<th>ER</th>
<th>OP</th>
</tr>
</thead>
<tbody>
<tr>
<td>History</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initial Facility</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subsequent Facility</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complexity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average time (minutes)</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

#### Domiciliary (e.g., Boarding Home) or Custodial Care Services and Home Care

<table>
<thead>
<tr>
<th>Service</th>
<th>ER</th>
<th>OP</th>
<th>ER</th>
<th>OP</th>
</tr>
</thead>
<tbody>
<tr>
<td>History</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Possession</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average time (minutes)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Specialty Exam: General Multisystem

#### Elements of Examination

**Neck**
- Examination of neck (e.g., masses, lymphadenopathy, superficial veins, carotids, jugular veins, cervical nodes, neck masses)
- Correlation of findings (e.g., elongation, tenderness, mass)
- Respiration (e.g., dyspnea, stridor, cough, wheezing)

**Chest**
- Examination of chest (e.g., palpitation, tactile fremitus, breath sounds, resonance)
- Auscultation of heart (e.g., tachycardia, tachypnea, turgor, atrial, ventricular, valvular, cardiac murmurs)

**Cardiovascular**
- Examination of heart (e.g., tachycardia, tachypnea, turgor, atrial, ventricular, valvular, cardiac murmurs)
- Auscultation of heart (e.g., tachycardia, tachypnea, turgor, atrial, ventricular, valvular, cardiac murmurs)

**Genitourinary**
- Examination of abdomen (e.g., masses, tenderness, distention, and palpation of organs)
- Rectal examination (e.g., masses, tenderness, distention, and palpation of organs)

**Musculoskeletal**
- Examination of joints (e.g., range of motion, pain, swelling, and tenderness)
- Auscultation of joints (e.g., range of motion, pain, swelling, and tenderness)

**Quick Reference Guide**

- **Important Medical Information**
  - **Diagnosis**
    - Chief complaint
    - History of present illness
    - Past medical history
    - Family history
    - Social history
    - Review of systems
  - **Physical Examination**
    - General appearance
    - Head and neck examination
    - Skin examination
    - Lymph nodes
    - Vascular examination
    - Cardiac examination
    - Respiratory examination
    - Gastrointestinal examination
    - Genitourinary examination
    - Musculoskeletal examination
    - Neurological examination
    - Mental status examination

---

**Practice Management Institute**
www.pmiMD.com

**Webinar/Audio Conference**
March 21, 2019

---

**Image 1**

- **System/Body Area**: Elements of Examination
  - **Neck**: Examination of neck (e.g., masses, lymphadenopathy, superficial veins, carotids, jugular veins, cervical nodes, neck masses)
  - **Chest**: Examination of chest (e.g., palpitation, tactile fremitus, breath sounds, resonance)
  - **Cardiovascular**: Examination of heart (e.g., tachycardia, tachypnea, turgor, atrial, ventricular, valvular, cardiac murmurs)

---

**Image 2**

- **System/Body Area**: Elements of Examination
  - **Neck**: Examination of neck (e.g., masses, lymphadenopathy, superficial veins, carotids, jugular veins, cervical nodes, neck masses)
  - **Chest**: Examination of chest (e.g., palpitation, tactile fremitus, breath sounds, resonance)
  - **Cardiovascular**: Examination of heart (e.g., tachycardia, tachypnea, turgor, atrial, ventricular, valvular, cardiac murmurs)

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**Image 3**

- **System/Body Area**: Elements of Examination
  - **Neck**: Examination of neck (e.g., masses, lymphadenopathy, superficial veins, carotids, jugular veins, cervical nodes, neck masses)
  - **Chest**: Examination of chest (e.g., palpitation, tactile fremitus, breath sounds, resonance)
  - **Cardiovascular**: Examination of heart (e.g., tachycardia, tachypnea, turgor, atrial, ventricular, valvular, cardiac murmurs)
Medical Necessity

- According to Medicare.gov, “medically necessary” is defined as “health-care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine.”

- For a service to be considered medically necessary, it must be reasonable and necessary to diagnosis or treat a patient’s medical condition.

- When submitting claims for payment, the diagnosis codes reported with the service tells the payer "why" a service was performed. The diagnosis reported helps support the medical necessity of the procedure.
Example

• **For example**, a patient presents to the office with chest pain and the physician orders an electrocardiogram (ECG).
• A 12-lead ECG performed in the office and interpreted by a physician is reported with CPT® code 93000.
• The **reason** the physician orders the ECG is because the patient is complaining of chest pain. The diagnosis code for unspecified chest pain is R07.9.

• In this case, the provider should be queried why the chest X-ray was ordered so the proper diagnosis can be reported.
• The provider may have wanted a knee X-ray and made a mistake when writing his orders. By **asking the provider for clarification**, you have prevented the performance of an unnecessary test because the provider really intended to order a knee X-ray.
• In this case, the knee pain would **support** the order of the knee X-ray. If the provider intended to order a chest X-ray, by asking for clarification you can report the service with a more appropriate ICD-10-CM code and **eliminate a claim denial.**
• The provider must document the diagnosis for all procedures that are performed. The provider also must include the diagnosis for each diagnostic test ordered.
• A common error seen when reviewing medical documentation is that the provider will document a diagnosis and indicate tests ordered, but it is unclear that all the tests ordered are for the diagnosis documented in the assessment.
• For example, the patient presents with right knee pain and the physician performs an arthrocentesis. He also orders a chest X-ray. The only diagnosis documented is knee pain. The knee pain supports the medical necessity for performing the arthrocentesis, but it does not support the medical necessity for the chest X-ray.

Case Study

• **CC:** Seeking a new primary physician
• **HPI:** The patient is a pleasant 65 year old female who presents to establish care with a local primary physician after moving to this area recently, to be near her daughter. She has a **history of hypertension and type II diabetes, both controlled with medications.** She also has a history of coronary artery disease, which has been asymptomatic for the last three years following PTCA deploying 2 stents. **She has no spontaneous current complaints.**
• **ROS:** Complete ROS was performed and documented and was positive for **intermittent lower extremity edema and easy bruising.** For more details, please refer to the ROS questionnaire with today’s date located in the chart.
• **Medications:** Atenolol 25 mg PO QD. Glyburide 5 mg PO BID. Lisinopril 10 mg PO BID. Atorvastatin 20 mg PO QD.
• **PMH:** In addition to the HPI, **she has osteoarthritis.**
• **SH:** The patient has been widowed for 5 years. She denies tobacco or alcohol abuse.
Exam:

- **Vitals:** 116/70, 80, 97.9
- **General Appearance:** NAD, well conversant
- **Eyes:** Anicteric sclerae, moist conjunctiva; no lid-lag; PERRLA.
- **HEENT:** AT/NC; oropharynx clear with MMM and no mucosal ulcerations; auditory canals patent with pearly TMs. Normal hard and soft palate.
- **Neck:** Trachea midline; FROM, supple, no thyromegaly or lymphadenopathy.
- **Lungs:** CTA, with normal respiratory effort and no intercostal retractions.
- **CV:** RRR, no MRGs
- **Abdomen:** Soft, non-tender; no masses or HSM.
- **Extremities:** No peripheral edema or extremity lymphadenopathy.
- **Skin:** Normal temperature, turgor and texture; no rash, ulcers or nodules.
- **Psych:** Appropriate affect, alert and oriented to person, place and time.
- **Labs:** HGBA1c 6.8; BUN 25, creatinine 0.8; LDL 86, HGB 12

Assessment:
1. Well controlled essential hypertension
2. Optimally controlled NIDDM
3. Stable CAD

Plan:
1. Continue current medications unchanged
2. Return visit in two months
3. Will repeat HGBA1c, CBC, and renal profile
4. Will repeat LFTs since patient is on statin medication
5. Will re-check microalbumin/creatinine
### Rationale

**HPI:** Status of chronic conditions:
- 1 condition
- 2 conditions
- 3 conditions

**OR**

**HPI (history of present illness) elements:**
- Location
- Severity
- Timing
- Modifying factors
- Quality
- Duration
- Context
- Associated signs and symptoms

**ROS (review of systems):**
- Constitutional
- Cardiac
- Respiratory
- Musculoskeletal
- Integumentary
- Gastrointestinal
- Endocrine
- Neurological
- Psychiatric
- All others negative

**PFH (past medical, family, social history) areas:**
- Past medical (a review of previous illnesses, operations, injuries, and treatments)
- Family history (a review of medical events in the patient’s family, including diseases which may be hereditary or place the patient at risk)
- Social history (an appropriate review of past and current activities)

**Complete ROS:** 10 or more systems or the pertinent positives and/or negatives of some systems with a statement "all others negative."

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**Problem Focused Examination:** 1 - 5 elements identified by a bullet
**Expanded Problem Focused Examination:** 6 or more elements identified by a bullet
**Detailed Examination:** 2 or more elements identified by a bullet from each of 5 areas/systems or at least 12 elements identified by a bullet
**Comprehensive Examination:** 2 or more elements identified by a bullet from each of 9 areas/systems

| Constitutional | Vital Signs (3 of the following 7):
|               | height, weight, temperature, pulse, respiration, sitting or standing blood pressure, supine blood pressure. |
|               | General appearance |
| Eyes          | Inspection of conjunctiva & lids |
|              | Examination of pupils & irises |
|              | Ophthalmoscopic examination of optic disc/posterior segment |
| Ears Nose Mouth Throat | External inspection of ears & nose |
|                | Otoendoscopic examination of external ear & tympanic membrane |
|                | Assessment of hearing |
|                | Inspection of nasal mucosa, septum & turbinates |
|                | Inspection of lips, teeth & gums |
|                | Examination of oropharynx: oral mucosa, salivary glands, palate, tonsils, tongue & posterior pharynx |
| Lymphatic     | Palpation of lymph nodes in 2 or more areas: |
|               | Axilla |
|               | Groin |
|               | Neck |
| Musculoskeletal | Examination of gait/station |
|                | Inspection of palpation of digits &
# Rationale

Examination – Comprehensive (20 Bullets)

- Constitutional – Bullet #1, Bullet #2
- Eyes – Bullet #1, Bullet #2
- Ears, nose, mouth, & throat – Bullet #1, Bullet #6
- Neck – Bullet #1, Bullet #2
- Respiratory – Bullet #1, Bullet #4
- Cardiovascular – Bullet #2, Bullet #7
- Gastrointestinal – Bullet #1, Bullet #2
- Lymphatic – Bullet #1, Bullet #4
- Skin – Bullet #1, Bullet #2
- Psychiatric – Bullet #2, Bullet #3
Rationale

Medical Decision Making – Moderate Complexity

- #Dx – Multiple (3 established and stable problems: hypertension, diabetes, and CAD)
- Data – Minimal
- Risk – Moderate
### Amount and/or Complexity of Data Reviewed

<table>
<thead>
<tr>
<th>Reviewed Data</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review and/or order of clinical lab tests</td>
<td>1</td>
</tr>
<tr>
<td>Review and/or order of tests in the radiology section of CPT</td>
<td>1</td>
</tr>
<tr>
<td>Review and/or order of tests in the medicine section of CPT</td>
<td>1</td>
</tr>
<tr>
<td>Discussion of test results with performing physician</td>
<td>1</td>
</tr>
<tr>
<td>Decision to obtain old records and/or obtain history from someone other than patient</td>
<td>2</td>
</tr>
<tr>
<td>Review and summarization of old records and/or obtaining history from someone other than patient and/or discussion of case with another health care provider</td>
<td>2</td>
</tr>
<tr>
<td>Independent visualization of image, tracing or specimen itself (not simply review of report)</td>
<td>2</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>1</strong></td>
</tr>
</tbody>
</table>

### Risk of Complications and/or Morbidity or Mortality

<table>
<thead>
<tr>
<th>Level of Risk</th>
<th>Presenting Problem(s)</th>
<th>Diagnostic Procedure(s) Under Stress</th>
<th>Management Options Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>One self-limited or minor problem, e.g., cold, muscle strain, skin cancers</td>
<td>Laboratory tests (e.g., urinalysis, chest x-ray)</td>
<td>Real, Gauze, Sterile bandages, Superficial dressings</td>
</tr>
<tr>
<td></td>
<td>One stable chronic disease, e.g., well controlled hypertension or non-smoke dependent diabetes, cancer, APN</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Acute uncomplicated illness or injury, e.g., cough, allergic rhinitis, simple laceration</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td>Two or more self-limited or minor problems</td>
<td>Psychological tests (e.g., urinalysis, chest x-ray)</td>
<td>Over-the-counter drugs, Minor surgery with no identified risk factors, Physical therapy, Occupational therapy, IV fluid therapy</td>
</tr>
<tr>
<td></td>
<td>One or more chronic diseases with mild exacerbation, progression, or side effects of treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Acute illness with systemic symptoms, e.g., viral meningitis, appendicitis, dermatitis</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Acute complicated injury, e.g., head injury with brief loss of consciousness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderate</td>
<td>One or more chronic diseases with severe exacerbation, progression, or side effects of treatment</td>
<td>Cardiac stress test, Endoscopic evaluation</td>
<td>Minor surgery with identified risk factors, Elective major surgery with severe exacerbation or side effects of treatment, other risk factors, Prevention of postoperative complications, Prevention of postoperative complications, Therapeutic nuclear medicine, IV fluids with additonal fluids, Closed treatment of fracture or dislocation without manipulation</td>
</tr>
<tr>
<td></td>
<td>Acute or chronic illnesses or other factors that may pose a threat to life or limbs, function, e.g., multiple trauma, acute MI, pulmonary artery embolism, severe respiratory distress, progressive heart failure, non-malignant cardiac arrhythmias</td>
<td>Cardiac stress test, Endoscopic evaluation, Cardiac and/or pulmonary artery catheterization, Coronary angiography</td>
<td></td>
</tr>
<tr>
<td></td>
<td>An abrupt change in medical status, e.g., sepsis, TIA, worsening or acute onset</td>
<td>Cardiac stress test, Endoscopic evaluation, Cardiac and/or pulmonary artery catheterization, Coronary angiography</td>
<td></td>
</tr>
<tr>
<td>High</td>
<td>One or more chronic diseases with severe exacerbation, progression, or side effects of treatment</td>
<td>Cardiac stress test, Endoscopic evaluation, Cardiac and/or pulmonary artery catheterization, Coronary angiography</td>
<td>Elective major surgery with severe exacerbation or side effects of treatment, Emergency major surgery with severe exacerbation or side effects of treatment, Prevention of postoperative complications, Prevention of postoperative complications, Therapeutic nuclear medicine, IV fluids with additonal fluids, Closed treatment of fracture or dislocation without manipulation, Decision not to resuscitate or to de-escalate care because of poor prognosis</td>
</tr>
</tbody>
</table>
Final Result for Complexity

Draw a line down any column with 2 or 3 circles to identify the type of decision making in that column. Otherwise, draw a line down the column with the 2nd circle from the left. After completing this table, which classifies complexity, circle the type of decision making within the appropriate grid in Section 5.

<table>
<thead>
<tr>
<th>A</th>
<th>Number diagnoses or treatment options</th>
<th>≤ 1</th>
<th>Minimal</th>
<th>2</th>
<th>Limited</th>
<th>Multiple</th>
<th>≥ 4</th>
<th>Extensive</th>
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<tbody>
<tr>
<td>B</td>
<td>Highest Risk</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Moderate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>Amount and complexity of data</td>
<td>≤ 1</td>
<td>Minimal</td>
<td>2</td>
<td>Limited</td>
<td>≥ 4</td>
<td></td>
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<tr>
<td></td>
<td>Type of decision making</td>
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</tr>
</tbody>
</table>

New Office / Outpatient / ER

Requires 3 components within shaded area

<table>
<thead>
<tr>
<th>History</th>
</tr>
</thead>
<tbody>
<tr>
<td>ER: PF</td>
</tr>
<tr>
<td>EPF</td>
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<tr>
<td>D</td>
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</table>

<table>
<thead>
<tr>
<th>Examination</th>
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<td>ER: PF</td>
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<td>D</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Complexity of medical decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>ER: SF</td>
</tr>
<tr>
<td>ER: L</td>
</tr>
<tr>
<td>ER: M</td>
</tr>
<tr>
<td>ER: H</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Average time (minutes)</th>
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<tbody>
<tr>
<td>10 New (99201)</td>
</tr>
<tr>
<td>20 New (99202)</td>
</tr>
<tr>
<td>30 New (99203)</td>
</tr>
<tr>
<td>45 New (99204)</td>
</tr>
<tr>
<td>60 New (99205)</td>
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<table>
<thead>
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<th>Level</th>
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<tbody>
<tr>
<td>I</td>
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<tr>
<td>II</td>
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<tr>
<td>III</td>
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<tr>
<td>IV</td>
</tr>
<tr>
<td>V</td>
</tr>
</tbody>
</table>
Tips, Tools & Techniques

• Have a written compliance plan in place
• Conduct audits on a regularly scheduled basis and provide feedback
• Track and train in areas of deficiency to maximize results and be “audit-proof”

"Top 10 Steps You Can Take to Improve Compliance and Stay Out of Trouble with the Government"

Sponsored by:
Liles Parker
Wednesday, March 6, 2019, 8:00pm (EST)
Presented by

Robert W. Liles, Esq. & Ismail Laher, Esq.
Liles Parker PLLC
(202) 298-8750
www.lilesparkerrc.com
Overview of the Current Enforcement Environment

Step #1: Get Back to Basics – Develop and Implement an Effective Compliance Plan.
Step #2: Common Errors Identified in a Gap Analysis.
Step #3: Administrative Audits and Actions are Increasing.
Step #4: Carefully Screen Your Employees, Contractors and Business Associates.
Step #5: Conduct Due Diligence Before Establishing a Business Relationship.
Step #6: Ensure that Copayments and Deductibles are Being Collected.
Step #7: Take Steps to Reduce the Likelihood of a False Claims Act Case.
Step #8: Analyze Your Business Relationships to Avoid Stark Violations.
Step #9: Don’t Violate State and Federal Anti-Kickback Statutes.
Step #10: HIPAA / IT Risks.
Overview of the Current Enforcement Environment
National Fraud Takedown 2018

• National Fraud Takedown. In June 2018, OIG investigators participated in the largest national healthcare fraud investigation in history, conducted across the United States in 51 federal districts, involving charges against more than 600 individuals for their alleged participation in schemes involving more than $2.0 billion in false billings to health care programs. Of those subjects charged, 165 were medical professionals — particularly doctors and nurses. Thirty Medicaid Fraud Control Units participated in the takedown.

• Charges outlined in recent criminal indictments included:
  - Submission of false and fraudulent claims;
  - Overbilling;
  - Illegal use of Identities;
  - False patient information;
  - Solicitation of referrals;
  - Provider kickbacks and bribes;
  - Medical identity theft;
  - Forgery of physician’s signature;
  - Billing for services by unlicensed individuals;
  - Unsupervised staff;
  - Employment of excluded individuals;
  - Filing claims with names and identifiers for dead people.
Questions?

- Thank you for your attendance!

- Get your questions answered. Email info@pmiMD.com

Thank you!
You Made My Day