Evolution of the Medical Record

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AAPC
Advancing the Business of Healthcare

‘Why I Became a Doctor’

“My decision to become a doctor was driven largely by values instilled in me by my faith and my family. The idea of being a part of a profession focused on helping others regardless of circumstance, focused on facilitating people leading healthier and therefore happier lives … I can’t imagine a more fulfilling job.”

- Erica Marsh, MD

Medicine, Michigan. “'Why I Became a Doctor': Michigan Medicine Physicians Share Their Stories.” Why I Became a Doctor: Physician Stories From Michigan Medicine Professionals, 30 Mar. 2017, labblog.uofmhealth.org/rounds/why-i-became-a-doctor.

‘Why I Became a Doctor’

While still in high school, I did an aptitude test which said I could "do anything" which didn't help the career decision-making process. My 11th grade English teacher said that she thought I would "make a good doctor" so I applied for medicine based on that. The rest, as they say, is history!

- *Unknown*

Drummond. “How Physicians Decide to Become Doctors.” *Stop Physician Burnout Tools, Coaching, Training - Physician Wellness Program Design and Implementation - The Happy MD*, www.thehappymd.com/blog/bid/339785/how-physicians-decide-to-become-doctors.

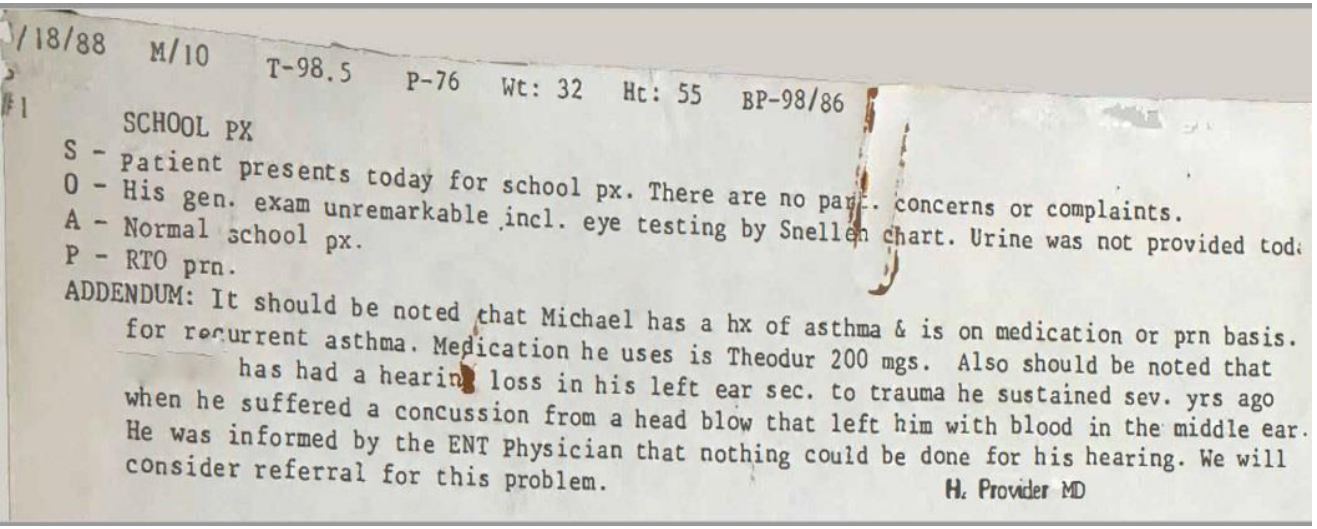
‘Why I Became a Doctor’

I was inspired by the need for diversity in the medical community. I took it personally that people of color made up such a small percentage of providers not only in my community but nationwide.

- Kristian Black

Black, Kristian. “Inspiring Stories.” *Medical Careers*, Associate of American Medical Colleges, students-residents.aamc.org/choosing-medical-career/article/kristian-black/.

How Did We Get Here?



/18/88 M/10 T-98.5 P-76 Wt: 32 Ht: 55 BP-98/86

#1

SCHOOL PX

S - Patient presents today for school px. There are no par[illegible]. concerns or complaints.
O - His gen. exam unremarkable incl. eye testing by Snellen chart. Urine was not provided tod
A - Normal school px.
P - RTO prn.
ADDENDUM: It should be noted that Michael has a hx of asthma & is on medication or prn basis. for recurrent asthma. Medication he uses is Theodur 200 mgs. Also should be noted that has had a hearin[illegible] loss in his left ear sec. to trauma he sustained sev. yrs ago when he suffered a concussion from a head blow that left him with blood in the middle ear. He was informed by the ENT Physician that nothing could be done for his hearing. We will consider referral for this problem.

H. Provider MD

Peds History of Present Illness
Chief Complaint: Patient presents for school physical without specific complaints or concerns.
Peds HPI Source: Parent
Peds HPI Exam limitations: No Limitations
Allergies/ Adverse Reactions: No Known Allergies Allergy (Verified 03/27/20 15:51)
Immunizations: Peds HPI Immunizations: Up to date
Home Medications: Theophylline ER [Theodur] 200 mg PO
Narrative of Present Illness: Patient presents for school physical without specific complaints or concerns.
Past Medical History
Birth History Problems: Normal birth history
Past Medical History: Asthma, Other (Hearing loss to AD due to head trauma, blood in middle ear)
Past Surgical History: No surgical history
Caffeine Intake: No
Sporting Activities: Baseball, Basketball, Football
Parents Marital Status: Married
Smoking History: Never
Exposure to Second Hand Smoke: No
Lives With: Parents
Attends: School
Peds Year in School: 5th grade

Review of Symptoms
Eyes: No symptoms reported
HENT: No symptoms reported
Cardiovascular: No symptoms reported
Respiratory: No symptoms reported
Gastrointestinal: No symptoms reported
Genitourinary: No symptoms reported
Musculoskeletal: No symptoms reported
Integumentary: No symptoms reported
Neurologic/Psychiatric: No symptoms reported
Endocrine: No symptoms reported
Hematologic/Lymphatic: No symptoms reported
Allergies/Immunologic: No symptoms reported

Exam
Vital Signs: BP: 98/86 HR: 76 bpm RR: 14 /min TEMP: 98.5
General Appearance: No apparent distress, Active and alert
Level of Distress: No acute distress
Attentiveness: Attentive, Sleeping but easily aroused

What is a Medical Record?

- Continuity of care
  - Document patient's medical problems and conditions
  - Record patient medical histories
- Used as a legal document
- Support for tracking health statistics
- Support claims to insurance carriers
- Assess the quality of care

Continuity of Care

10/21/88 M/10 T-98.2 P-90 Wt: 32.8 kgs BP-90/58 [redacted]

[redacted]

#2 BILAT. FOOT & TOE PAIN OF UNCLEAR ETIOLOGY : R/O VASCULITIS

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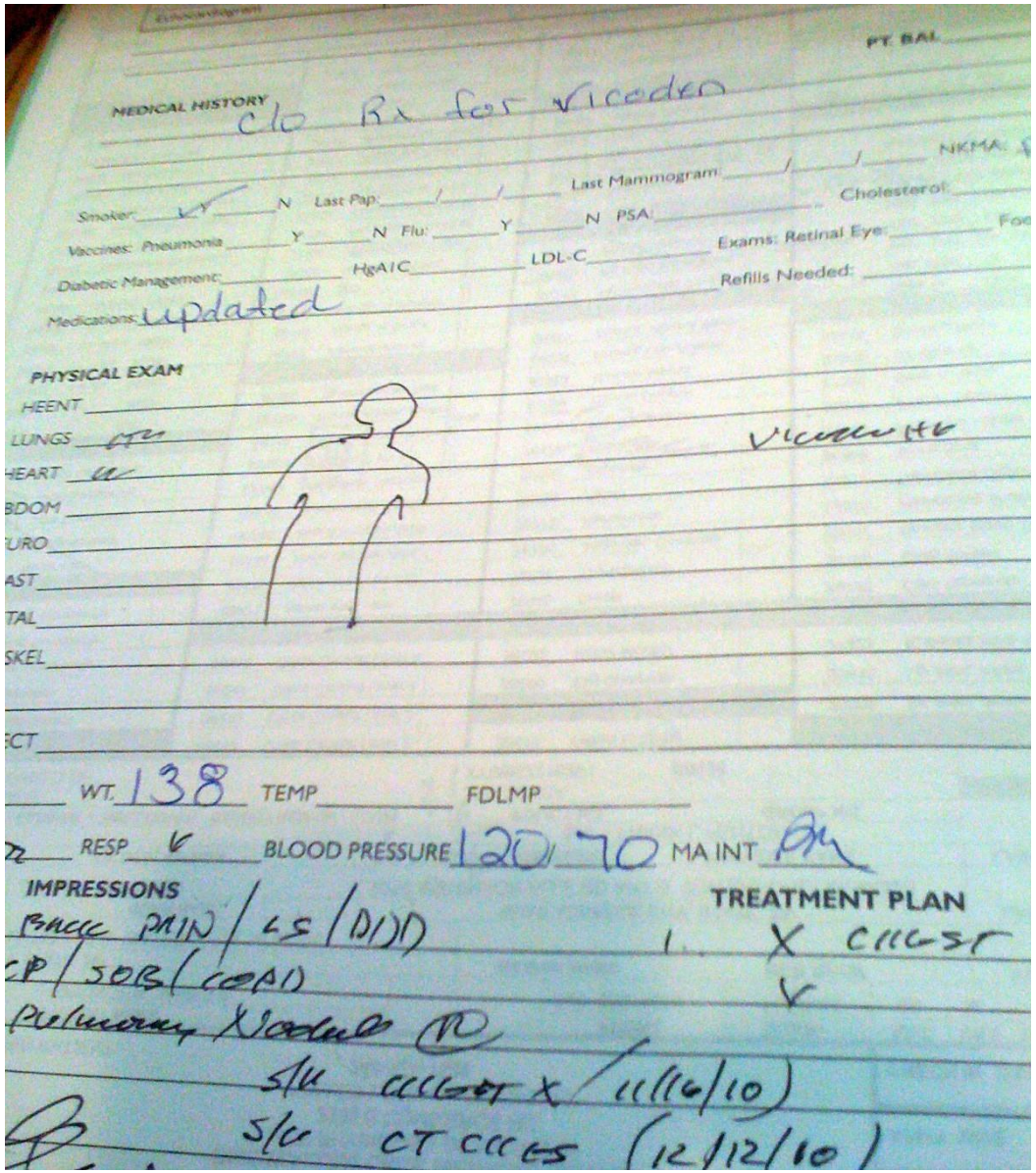
[redacted] MD

Continuity of Care



Legal Document

- Medical records can be used:
  - Medical Malpractice Litigation
    - Medical Records as a Plaintiff's Weapon
    - Defensible Records
  - Administrative Review of Records
  - Criminal Discovery
  - Quality Assurance and Accreditation Review

Richards, Edward. "Public Health Law Map - Beta 5.7." *Legal Uses of Medical Records*, LSU Law Center, 2009, biotech.law.lsu.edu/map/LegalUsesofMedicalRecords.html.

Legal Document

- *"Records are particularly important for a physician's defense. The patient has injuries to show the court; the physician or other medical care practitioner has only the medical records to prove that the injuries were not due to negligence. If the record is incomplete, illegible, or incompetently kept, this is the health care practitioner's failure. Although courts and juries usually give a defendant the benefit of the doubt on ambiguous matters, this does not extend to ambiguities created by incompetent recordkeeping. The least credible records are those that are internally inconsistent—for example, the physician's progress notes report that the patient was doing well and improving steadily, but the nurses' records indicate that the patient had developed a high fever and appeared to have a major infection. More commonly, the credibility of the records is attacked through demonstrating that it is incomplete. If it is clear that medically important information is missing from the record, then it is easier to convince a jury that the missing information supports the patient's claims."*

Richards, Edward. "Public Health Law Map - Beta 5.7." *Legal Uses of Medical Records*, LSU Law Center, 2009, biotech.law.lsu.edu/map/LegalUsesofMedicalRecords.html.

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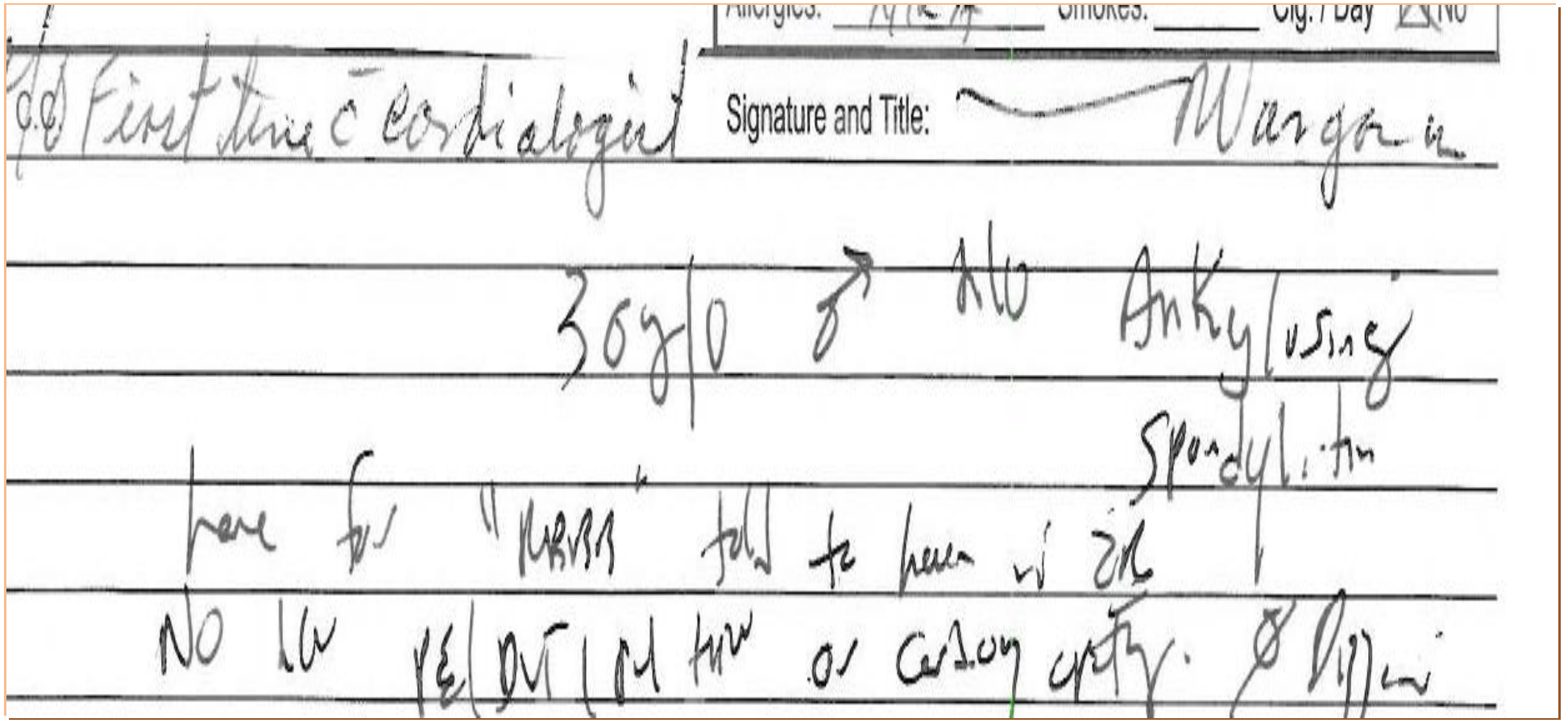
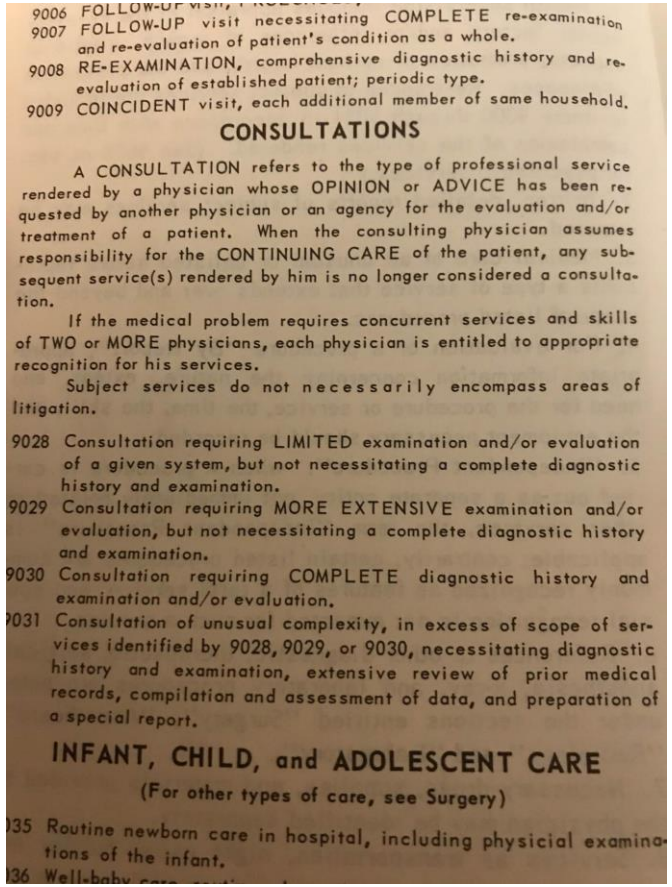


Statistical Tracking



9006 FOLLOW-UP visit, [illegible]
9007 FOLLOW-UP visit necessitating COMPLETE re-examination and re-evaluation of patient's condition as a whole.
9008 RE-EXAMINATION, comprehensive diagnostic history and re-evaluation of established patient; periodic type.
9009 COINCIDENT visit, each additional member of same household.

CONSULTATIONS

A CONSULTATION refers to the type of professional service rendered by a physician whose OPINION or ADVICE has been requested by another physician or an agency for the evaluation and/or treatment of a patient. When the consulting physician assumes responsibility for the CONTINUING CARE of the patient, any subsequent service(s) rendered by him is no longer considered a consultation.

If the medical problem requires concurrent services and skills of TWO or MORE physicians, each physician is entitled to appropriate recognition for his services.

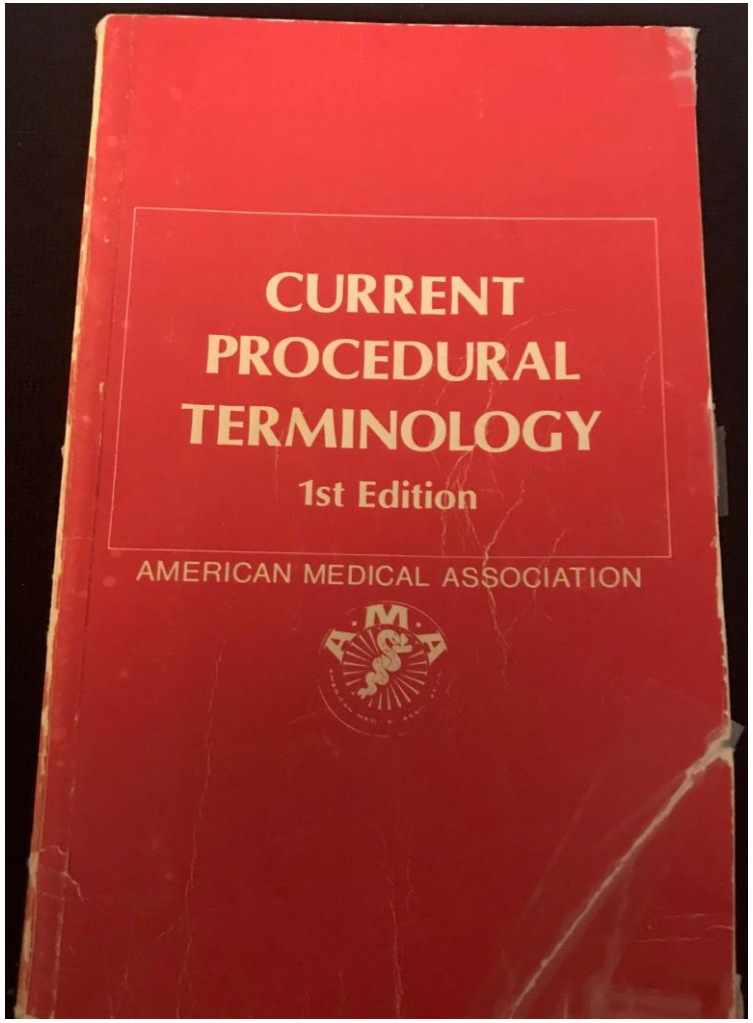
Subject services do not necessarily encompass areas of litigation.

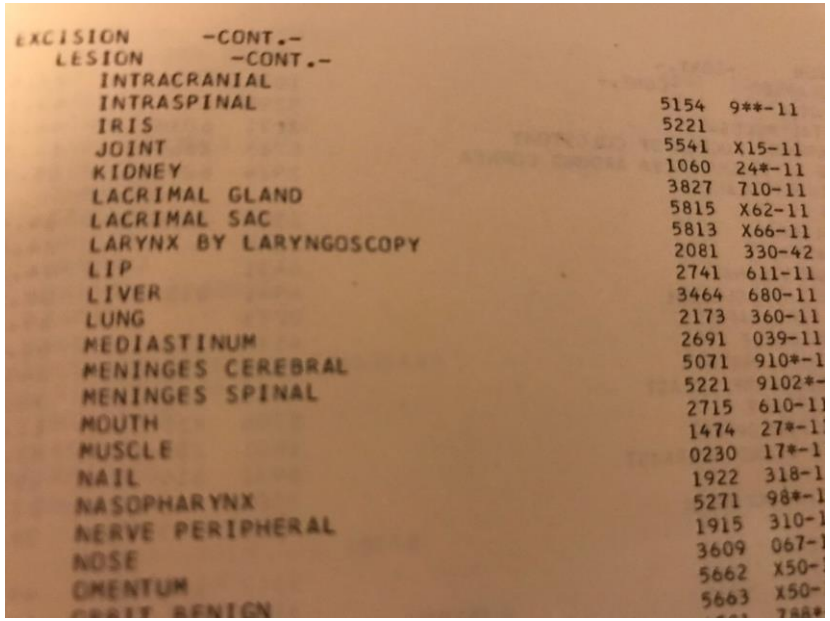
9028 Consultation requiring LIMITED examination and/or evaluation of a given system, but not necessitating a complete diagnostic history and examination.
9029 Consultation requiring MORE EXTENSIVE examination and/or evaluation, but not necessitating a complete diagnostic history and examination.
9030 Consultation requiring COMPLETE diagnostic history and examination and/or evaluation.
9031 Consultation of unusual complexity, in excess of scope of services identified by 9028, 9029, or 9030, necessitating diagnostic history and examination, extensive review of prior medical records, compilation and assessment of data, and preparation of a special report.

INFANT, CHILD, and ADOLESCENT CARE

(For other types of care, see Surgery)

9135 Routine newborn care in hospital, including physicial examinations of the infant.
9136 Well-baby care [illegible]





EXCISION -CONT.-		
LESION -CONT.-		
INTRACRANIAL	5154	9**-11
INTRASPINAL	5221	
IRIS	5541	X15-11
JOINT	1060	24*-11
KIDNEY	3827	710-11
LACRIMAL GLAND	5815	X62-11
LACRIMAL SAC	5813	X66-11
LARYNX BY LARYNGOSCOPY	2081	330-42
LIP	2741	611-11
LIVER	3464	680-11
LUNG	2173	360-11
MEDIASTINUM	2691	039-11
MENINGES CEREBRAL	5071	910*-1
MENINGES SPINAL	5221	9102*-
MOUTH	2715	610-1
MUSCLE	1474	27*-1
NAIL	0230	17*-1
NASOPHARYNX	1922	318-1
NERVE PERIPHERAL	5271	98*-1
NOSE	1915	310-1
OMENTUM	3609	067-1
	5662	X50-
	5663	X50-

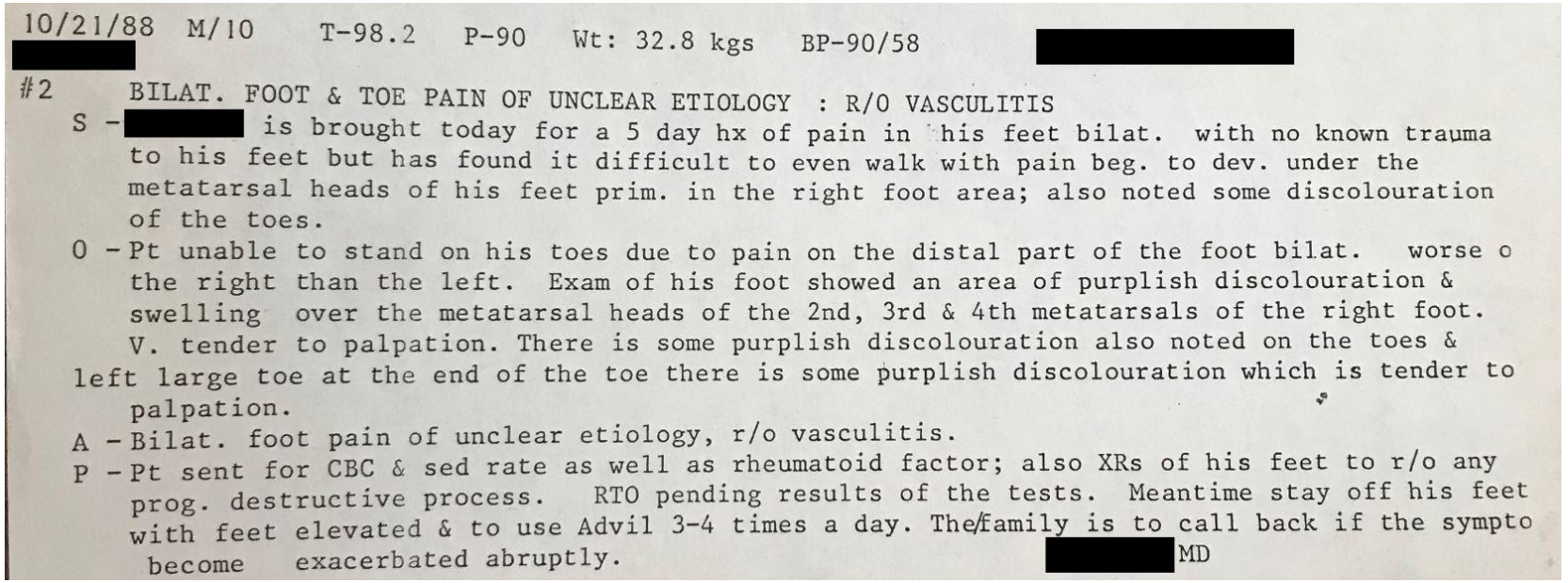
Courtesy of:
Suzanne Quinten

Support Claims to Ins. Carriers

- 1983 – Health Care Financing Administration (HCFA, now CMS) adopted CPT® codes for reporting physician services
- 1987 – HCFA adopted CPT® for outpatient surgical procedures

CPT Code and Corresponding Level		
Office	**Level**	**Hospital**
90030	Minimal	N/A
90040	Brief	90240
90050	Limited	90250
90060	Intermediate	90260
90070	Extended	90270
90080	Comprehensive	90280

Support Claims to Ins. Carriers



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90050	Limited
90060	Intermediate
90070	Extended
90080	Comprehensive

Support Claims to Ins. Carriers

- 1989 – OIG Office of Analysis and Inspections issued a report:
  Problems With Coding of Physicians Services: Medicare Part B

- **Purpose:**
  (1) determine whether there are significant problems regarding coding of physician office and hospital visits;
  (2) identify and examine reasons for coding problems; and
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  - Consult with the AMA on terminology changes and modification of the CPT manual

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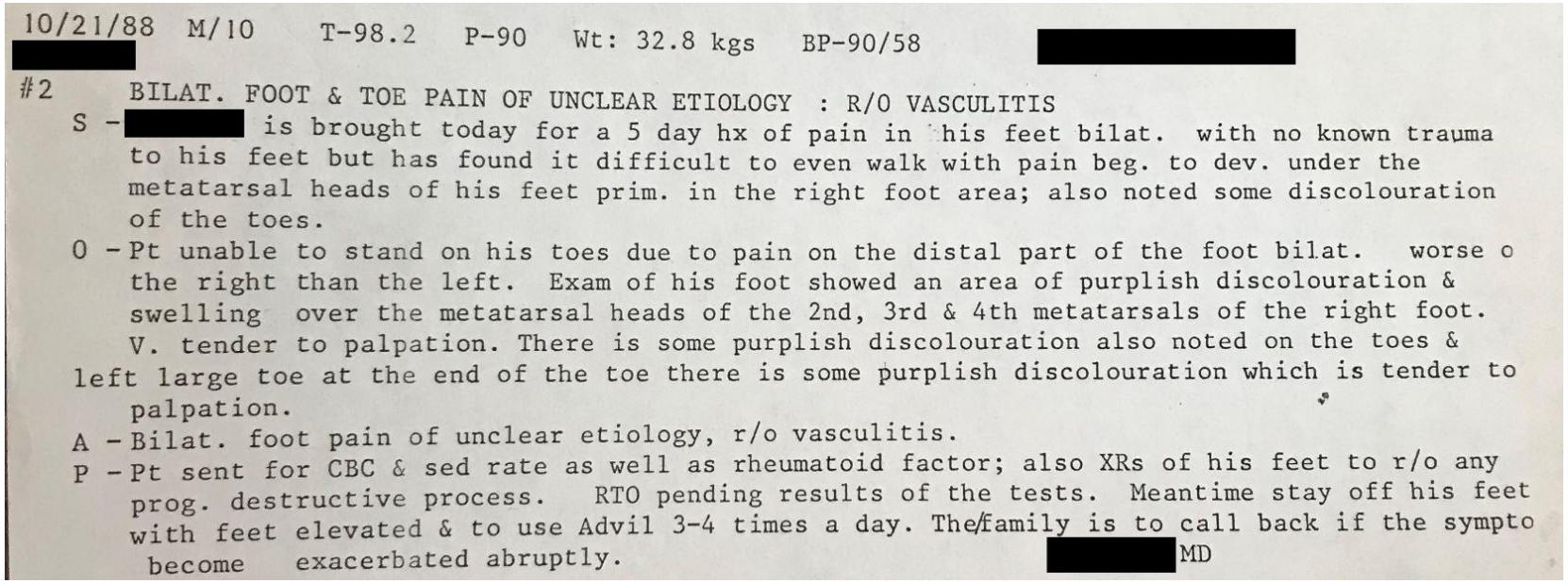
  - Consolidate codes for payment purposes.
  - Designate codes “routine” office and hospital visits.
  - Consult with the AMA on terminology changes and modification of the CPT manual
  - Education providers on proper coding.

1992 CPT® Codes

- 1992 – limited use of EMRs, mainly by scanning for document capture
- 1992 – E/M code descriptions were introduced in CPT®
  - Office visit codes divided into five levels
  - New patient office visits require 3/3 key components
    Est patient office visits require 2/3 key components
  - Key components: history, exam, medical decision making
  - Time

CPT® Code Crosswalk		
Office	**New Code**	**1992 Total RVU**
90030	99211	0.43
90040	99212	0.72
90050	99213	1.00
90060	99213	1.00
90070	99214	1.52
90080	99215	2.34

1992



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[redacted] MD

Code	99212	99213	99214	99215
History	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
Exam	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
MDM	Straightforward	Low	Moderate	High
Typical Time	10 min	15 min	25 min	40 min

1995 E/M Guidelines

Type of History	CC	HPI	ROS	PFSH
Problem Focused	Required	Brief	N/A	N/A
Expanded Problem Focused	Required	Brief	Problem Pertinent	N/A
Detailed	Required	Extended	Extended	Pertinent
Comprehensive	Required	Extended	Complete	Complete

Type of Examination	Description
Problem Focused	Limited exam of the affected body area or organ system
Expanded Problem Focused	Limited exam of the affected body area or organ system and other symptomatic or related organ system(s)
Detailed	Extended exam of the affected body area(s) and other symptomatic or related organ system(s)
Comprehensive	General multi-system examination or complete examination of a single organ system

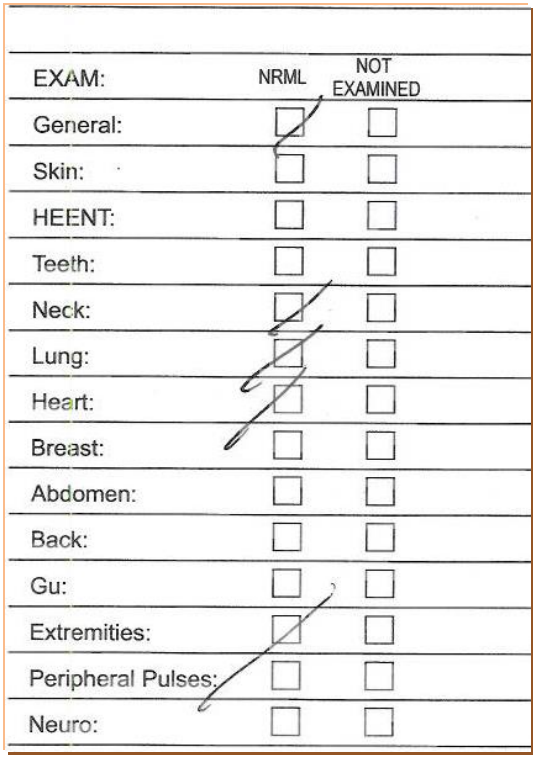
Number of diagnoses or management options	Amount and/or complexity of data to be reviewed	Risk of complications and/or morbidity or mortality	Type of decision making
Minimal	Minimal or None	Minimal	Straightforward
Limited	Limited	Limited	Low Complexity
Multiple	Moderate	Moderate	Moderate Complexity
Extensive	Extensive	High	High Complexity

1995 E/M Guidelines

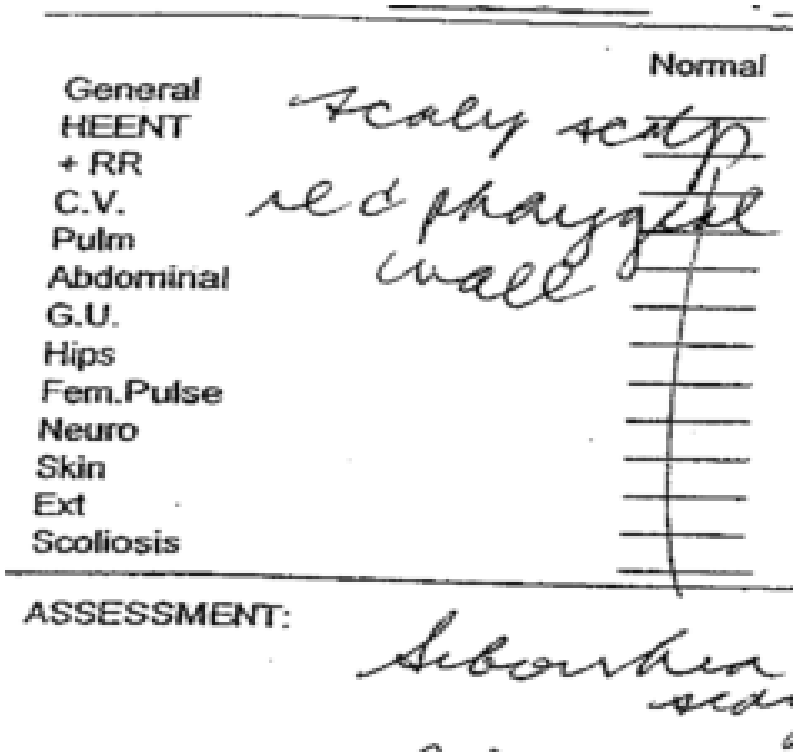
- 10/21/88 M/10 T-98.2 P-90 Wt.: 32.8kgs BP-90/58 (constitutional exam)
- CC: Bilat. Foot & Toe Pain of unclear etiology: R/O vasculitis (chief complaint)
- S – The patient is brought today for a 5 day hx (duration) of pain in his feet bilat (location). with no known trauma to his feet (context) but has found it difficult to even walk (severity) with pain beg. to dev. under the metatarsal heads of his feet prim. in the right foot area (ROS: MS); also noted some discoloration of the toes (associated signs & symptoms).
- O-Pt unable to stand on his toes due to pain on the distal part of the foot bilat. worse on the right than the left. Exam of his foot showed an area of purplish discoloration & swelling over the metatarsal heads of the 2nd, 3rd, & 4th metatarsals of the right foot. V. tender to palpation. There is some purplish discoloration also noted on the toes & left large toe at the end of the toe there is some purplish discoloration which is tender to palpation.
  (Two extremities [body areas] or musculoskeletal system and integumentary system [organ systems])
- A-Bilat. foot pain of unclear etiology, r/o vasculitis.
- P-Pt. Sent for CBC & sed rate as well as rheumatoid factor; also, XRs of his feet to r/o any prog. destructive process. RTO pending results of the tests. Meantime stay off his feet with feet elevated & use Advil 3-4 times a day. The family is to call back if the symptoms become exacerbated abruptly. (Moderate MDM)

Templates

- 1994 - Woodrow Gandy, M.D. and Rob Langdon, M.D. develop the T-Sheet
- Documentation issues developed:



EXAM:	NRML	NOT EXAMINED
General:	☐	☐
Skin:	☐	☐
HEENT:	☐	☐
Teeth:	☐	☐
Neck:	☐	☐
Lung:	☐	☐
Heart:	☐	☐
Breast:	☐	☐
Abdomen:	☐	☐
Back:	☐	☐
Gu:	☐	☐
Extremities:	☐	☐
Peripheral Pulses:	☐	☐
Neuro:	☐	☐



	Normal
General	scaly scalp
HEENT	red pharynx
+ RR	
C.V.	
Pulm	
Abdominal	wall
G.U.	
Hips	
Fem.Pulse	
Neuro	
Skin	
Ext	
Scoliosis	

ASSESSMENT: seborrhea

1997 E/M Guidelines

System/Body Area	Elements of Examination
Musculoskeletal	• Examination of gait and station • Inspection and/or palpation of digits and nails (eg, clubbing, cyanosis, inflammatory conditions, petechiae, ischemia, infections, nodes) Examination of joints, bones and muscles of **one or more of the following six** areas: 1) head and neck; 2) spine, ribs and pelvis; 3) right upper extremity; 4) left upper extremity; 5) right lower extremity; and 6) left lower extremity. The examination of a given area includes: • Inspection and/or palpation with notation of presence of any misalignment, asymmetry, crepitation, defects, tenderness, masses, effusions • Assessment of range of motion with notation of any pain, crepitation or contracture • Assessment of stability with notation of any dislocation (luxation), subluxation or laxity • Assessment of muscle strength and tone (eg, flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements
Skin	• Inspection of skin and subcutaneous tissue (eg, rashes, lesions, ulcers) • Palpation of skin and subcutaneous tissue (eg, induration, subcutaneous nodules, tightening)

1997 E/M Guidelines

PATIENT NAME: **DATE OF SERVICE:** 10/21/88

CC: Bilat. foot & Toe Pain of Unclear Etiology: R/O Vasculitis

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- ❑ UNCHANGED FROM
- ❑ UNCHANGED FROM
- ❑ UNCHANGED FROM

Alcohol/Drug Use: Work Environment:

SYSTEM REVIEW:
MS: No known trauma to feet

PAST HISTORY:

FAMILY HISTORY:

SOCIAL HISTORY:

Smoking History:

CURRENT MEDS

None

ALLERGIES

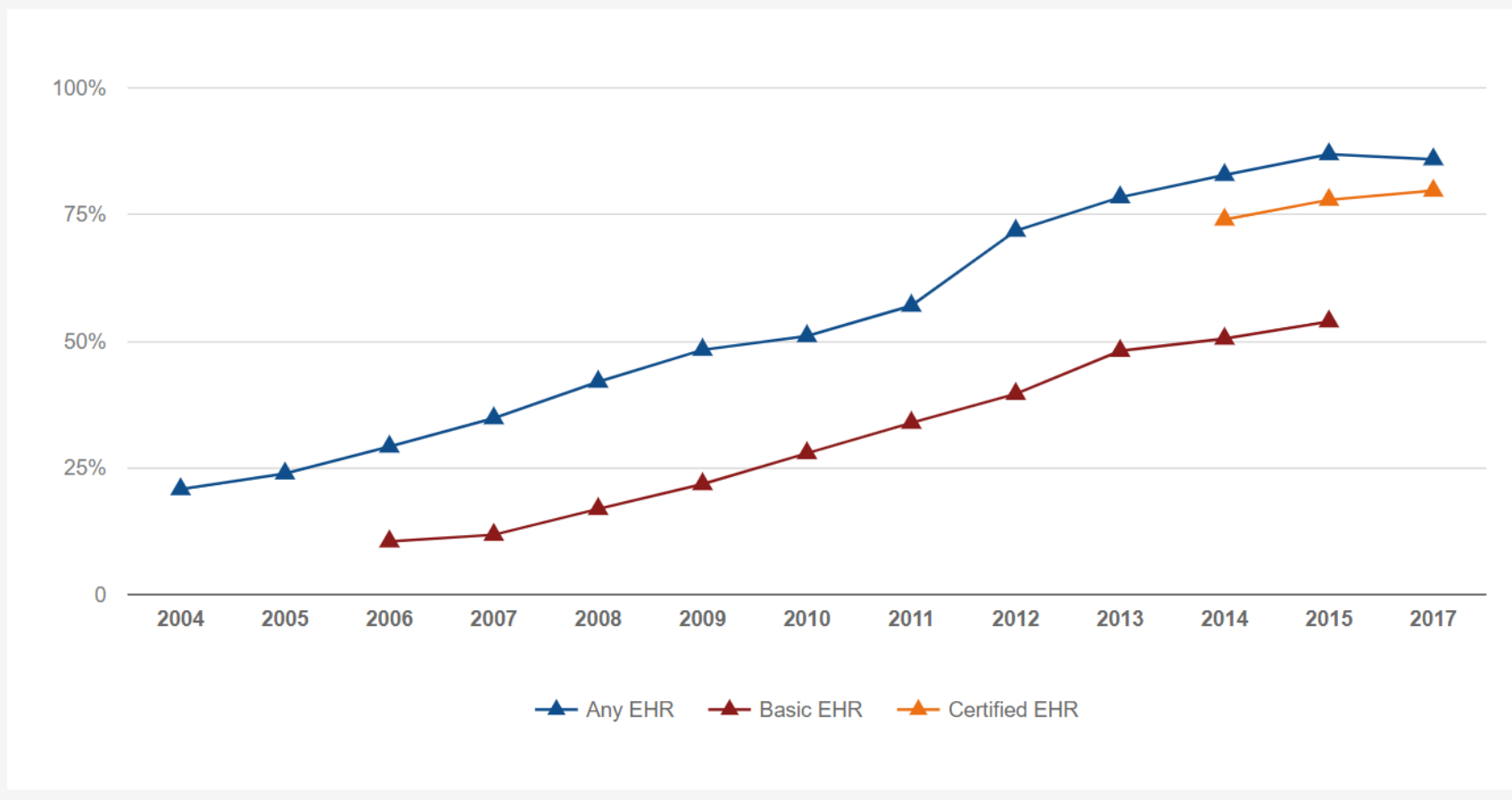
None

GENERAL MULTI-SYSTEM PHYSICAL EXAMINATION

Constitutional (3/6) P 90 T 98.2 BP 90/58 Wt 328kgs Ht Resp
General Appearance

		Normal	Positive Findings
Respiratory	Respiratory effort		
	Percussion of chest		
	Palpation of chest		
	Auscultation of lungs		
Cardiovascular	Palpation of heart		
	Auscultation of heart		
	Carotid arteries		
	Abdominal Aorta		
	Femoral arteries		
	Pedal pulses		
	Edema / varicosities		
Musculoskeletal	Gait and station		Exam of his foot showed an area of purplish discoloration & swelling over the metatarsal heads of the 2nd, 3rd, & 4th metatarsals of the right foot. V. tender to palpation.
	Digits and nails		
	Joints/bones/muscles 1>areas:		
	Inspection / palpation		
	Range of motion		
	Stability		
	Muscle strength and tone		
Skin	Inspection		There is some purplish discoloration also noted on the toes & left large toe at the end of the toe there is some purplish discoloration which is tender to palpation.
	Palpation		
Psychiatric	Description judgment / insight		
	Mental Status:		
	Orientation		
	Memory		
	Mood and affect		

Office-based Physician Electronic Health Record Adoption



Source: Office of the National Coordinator for Health Information Technology. 'Office-based Physician Electronic Health Record Adoption,' Health IT Quick-Stat #50. https://www.healthit.gov/data/quickstats/office-based-physician-electronic-health-record-adoption. January 2019.

Electronic Health Record

Patient reports: Reports: pain (bilateral feet x 5 days under the metatarsal heads of feet. primarily in right foot)
Peds HPI Immunizations: Up to date
Medications: None
Past Medical History: Asthma, Other (Hearing loss to AD due to head trauma, blood in middle ear)
Past Surgical History: No surgical history
Social History: Caffeine Intake: No; **Sporting Activities:** Baseball, Basketball, Football; **Parents Marital Status:** Married; **Smoking History:** Never; **Exposure to Secondhand Smoke:** No; **Lives With:** Parents; **Attends:** School; **Peds Year in School:** 5th grade

Review of Symptoms

Eyes: No symptoms reported
HENT: No symptoms reported
Cardiovascular: No symptoms reported
Respiratory: No symptoms reported
Gastrointestinal: No symptoms reported
Genitourinary: No symptoms reported
Musculoskeletal: No known trauma to feet
Integumentary: No symptoms reported
Neurologic/Psychiatric: No symptoms reported
Endocrine: No symptoms reported
Hematologic/Lymphatic: No symptoms reported
Allergies/Immunologic: No symptoms reported

Physical Exam

Vitals {Last 24H Min/Max): BP: 90/58, HR: 90 bpm, RR: 14 /min, TEMP: 98.2
General appearance: well developed, well nourished, in no acute distress
Head: normal inspections, atraumatic, normocephalic
Eye: PERRL, EOMI, normal ocular movement, normal vision
ENMT: mucosa moist, no discharge, normal mucosa, normal dentition, normal nares, normal pinna, no hearing loss, no congestion, no nasal discharge
Neck: non-tender, supple, trachea midline
Cardiovascular: regular rate & rhythm1 S1, S2+
Respiratory: clear to auscultation, aerating well, non labored
Abdomen: soft, non-tender, bowel sounds present, non-distended
Male GU: normal inspection
Extremities upper: non-tender, no joint swelling, no edema, no erythema, no cyanosis, full range of motion
Extremity lower: other (Pt unable to stand on toes due to pain in the distal part of both feet.)
Extremities lower: right abnormal inspection, right edema, right joint swelling, right ecchymosis (2nd,3rd,4th metatarsals), right tenderness location, bilaterally decreased ROM
Neurologic: alert and oriented x 3, CN II-XII intact, normal speech, no motor deficits, no sensory deficits, reflexes equal bilat, normal cerebellar function , normal gait
Coordination: normal finger to nose, negative Romberg's Sign
Motor/ sensory: no motor deficit, no sensory deficit, no pronator drift, negative Babinski's Sign
Psychological: appropriate mood, appropriate affect

A/P:

Bilateral foot pain **Code(s):** M79.671 - Pain in right foot; M79.672 - Pain in left foot **Problem;**
Description: r/o vasculitis **Status:** Acute ·
Plan: Evaluate CBC, Sed rate, rheumatoid factor; XRs of feet to r/o any progressive destructive process; Keep feet elevated; Advil 3-4 times per day; RTO for results or for worsening symptoms
Condition/Complexity: stable; **My Orders (last 16 hours):** cbc, sed rate, rheumatoid factor; **Plan Discussed with:** patient, mother; **Time Spent:** 15-30 minutes

2021 E/M Guidelines

- History and Exam – The nature and extent of the history and/or physical examination is determined by the treating physician or other QHP reporting the service.

10/21/88 M/10 T-98.2 P-90 Wt.: 32.8kgs BP-90/58

CC: Bilat. Foot & Toe Pain of unclear etiology: R/O vasculitis

S – The patient is brought today for a 5 day hx of pain in his feet bilat. with no known trauma to his feet but has found it difficult to even walk with pain beg. to dev. under the metatarsal heads of his feet prim. in the right foot area; also noted some discoloration of the toes.

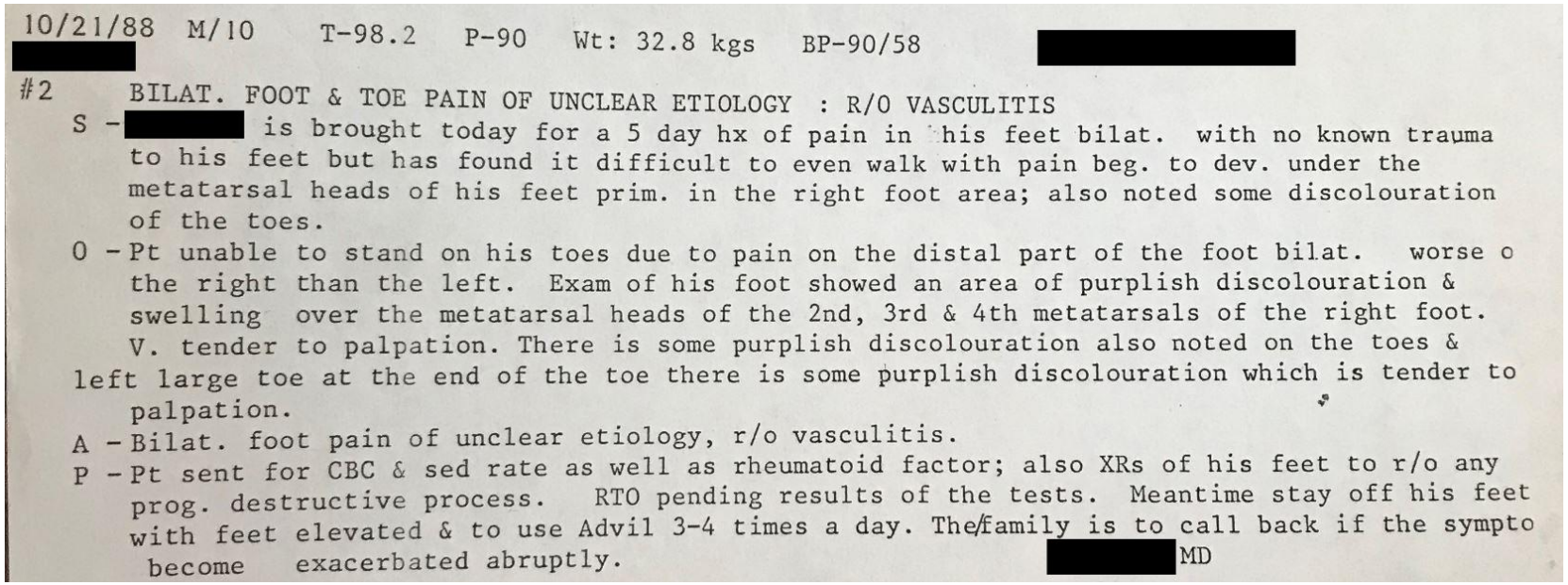
O-Pt unable to stand on his toes due to pain on the distal part of the foot bilat. worse on the right than the left. Exam of his foot showed an area of purplish discoloration & swelling over the metatarsal heads of the 2nd, 3rd, & 4th metatarsals of the right foot. V. tender to palpation. There is some purplish discoloration also noted on the toes & left large toe at the end of the toe there is some purplish discoloration which is tender to palpation.

2021 E/M Guidelines

A-Bilat. foot pain of unclear etiology, r/o vasculitis.(undiagnosed new problem with uncertain prognosis)

P-Pt. Sent for CBC (85025-85027) & sed rate (85651 or 85652) as well as rheumatoid factor (86430-86431); also, XRs of his feet (73620-73630) to r/o any prog. destructive process (4 tests). RTO pending results of the tests. Meantime stay off his feet with feet elevated & use Advil 3-4 times a day. The family is to call back if the symptoms become exacerbated abruptly.

Documentation Circles Back



10/21/88 M/10 T-98.2 P-90 Wt: 32.8 kgs BP-90/58 [redacted]

[redacted]

#2 BILAT. FOOT & TOE PAIN OF UNCLEAR ETIOLOGY : R/O VASCULITIS

S - [redacted] is brought today for a 5 day hx of pain in his feet bilat. with no known trauma to his feet but has found it difficult to even walk with pain beg. to dev. under the metatarsal heads of his feet prim. in the right foot area; also noted some discolouration of the toes.

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A - Bilat. foot pain of unclear etiology, r/o vasculitis.

P - Pt sent for CBC & sed rate as well as rheumatoid factor; also XRs of his feet to r/o any prog. destructive process. RTO pending results of the tests. Meantime stay off his feet with feet elevated & to use Advil 3-4 times a day. The family is to call back if the sympto become exacerbated abruptly.

[redacted] MD

Assess the Quality of Care

Childhood Immunization Status

Process

Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV), one measles, mumps and rubella (MMR); three or four H influenza type B (HiB); three hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.

+ ADD TO LIST

Collection Type and Documentation
Electronic clinical quality measures (eCQMs) Specifications

- Hide details

Measure Numbers	NQS Domain	Specialty Measure Set	Primary Measure Steward
CMS eCQM ID: CMS117v8 NQF eCQM ID: None NQF: None	Community/Population Health	Pediatrics	National Committee for Quality Assurance

Medication Management for People with Asthma

High Priority Measure: **Process**

The percentage of patients 5-64 years of age during the performance period who were identified as having persistent asthma and were dispensed appropriate medications that they remained on for at least 75% of their treatment period.

+ ADD TO LIST

Collection Type and Documentation
MIPS clinical quality measures (MIPS CQMs) Specifications (PDF)

- Hide details

Measure Numbers	NQS Domain	Specialty Measure Set	Primary Measure Steward
CMS eCQM ID: None NQF eCQM ID: None NQF: None Quality ID: 444	Efficiency and Cost Reduction	Family Medicine Internal Medicine Pediatrics Pulmonology	National Committee for Quality Assurance

What is a Medical Record?

- Continuity of care
- Used as a legal document
- Support for tracking health statistics
- Support claims to insurance carriers
- Assess the quality of care

2021 E/M Guidelines

Presented by: Katherine Abel, CPC, CPB, CPMA, CPPM, CPC-I, AAPC Fellow

AAPC
Advancing the Business of Healthcare

Objectives

- Review the 2021 E/M Guidelines
  - History and Exam
  - Medical Decision Making
  - Time
- Discuss revisions made to the 2021 E/M Guidelines
- Answer commonly asked questions

“If you just focus on the smallest details, you never get the big picture right.”

-Leroy Hood

2021 Reason for Change

- Reduce administrative burden
- Align with how patient care is delivered today
- Reduce the need for audits

CPT® E/M Instructions

Instructions for Selecting a Level of E/M Service for Hospital Observation, Hospital Inpatient, Consultations, Emergency Department, Nursing Facility, Domiciliary, Rest Home, or Custodial Care, and Home E/M Services

1. Review the Level of E/M Service Descriptors and Examples in the Selected Category or Subcategory
2. Determine the Extent of History Obtained
3. Determine the Extent of Examination Performed
4. Determine the Complexity of Medical Decision Making
5. Select the Appropriate Level of E/M Services Based on the Following:
   - Key components
   - Counseling or Coordination of Care when more than 50%

1995 & 1997 E/M Guidelines

Instructions for Selecting a Level of Office or Other Outpatient E/M Services

Select the appropriate level of E/M services based on the following:

1. The level of the MDM as defined for each service, **or**
2. The total time for E/M services performed on the date of the encounter.

2021 E/M Guidelines

2021 E/M Guidelines

Code descriptor

Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.

When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.

2021 E/M Guidelines

- Code selection based on MDM or time

Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.

When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.

Commonly Asked Question

- What do the 2021 E/M Guidelines apply to?

CPT® E/M Instructions

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2021 E/M Guidelines

Commonly Asked Question

- What do the 2021 E/M Guidelines apply to?

2021 E/M Guidelines	1995 & 1997 Guidelines
99203 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.	99222 Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: • A comprehensive history; • A comprehensive exam; • Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of moderate severity. Typically, 50 minutes are spent at the bedside and on the patient's hospital floor or unit.

Commonly Asked Question

- What do the 2021 E/M Guidelines apply to?

2021 E/M guidelines are **ONLY** used with codes 99202-99215

Commonly Asked Question

- Do the 2021 E/M Guidelines for Office or Other Outpatient Services apply for services reported to CMS?

Commonly Asked Question

- Do the 2021 E/M Guidelines for Office or Other Outpatient Services apply for services reported to CMS?

Effective January 1, 2021 CMS is aligning E/M coding with changes adopted by the American Medical Association (AMA) Current Procedural Terminology (CPT) Editorial Panel for office/ outpatient E/M visits, which:

- Retains 5 levels of coding for established patients, reduces the number of levels to 4 for office/outpatient E/M visits for new patients, and revises the code definitions
- Revises the times and medical decision-making process for all of the codes, and requires performance of history and exam only as medically appropriate
- Allows clinicians to choose the E/M visit level based on either medical decision making or time

For more information, review the CY 2021 Physician Fee Schedule Web Page and the Medicare Learning Network®(MLN) Connects Physician Fee Schedule Final Rule: Understanding 4 Key Topics Call transcript, recording and presentation.

Commonly Asked Question

- Do the 2021 E/M Guidelines for Office or Other Outpatient Services apply for services reported to CMS?

CMS and CPT® both require the 2021 E/M guidelines for codes 99202-99215

Requirements for Documentation

- Reason for the encounter
- Patient history
- Examination
- Review of prior test results
- Assessment
- Plan of care
- Date and identity of the provider performing the service

Requirements for Documentation

- Reason for ordering diagnostic tests and ancillary services
- Appropriate health risk factors
- Patient's response to treatment and any changes in treatment
- Procedure codes and diagnosis codes should be supported by the documentation
- The information must be legible

Commonly Asked Question

- Do the requirements for both MDM and Time have to be met to reach the level of office visit?

Instructions for Selecting a Level of Office or Other Outpatient E/M Services

Select the appropriate level of E/M services based on the following:

1. The level of the MDM as defined for each service, **or**
2. The total time for E/M services performed on the date of the encounter.

99202

Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.

When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.

Commonly Asked Question

- Do the requirements for both MDM and Time have to be met to reach the level of office visit?

No, which ever criteria best describes the work done should be documented.

Time Documentation Recommendations

- Include only the time for the date of service
- Clinical staff time can not be included
- Time spent performing other billable services can not be included
- Total time needs to be documented
  - Not required to associate the time to each activity
- Activities performed need to be documented
- Audit concerns

Do not count time spent on the following:
- The performance of other services that are reported separately
- Travel
- Teaching that is general and not limited to discussion that is required for the management of a specific patient

Commonly Asked Question

- Can the time spent by a resident be included when billing based on time?

Commonly Asked Question

- Can the time spent by a resident be included when billing based on time?

CMS Teaching Physician Guidelines for reporting resident services for time-based codes have not changed.

Prolonged Services Confusion

- New prolonged services codes used only with level 5 when time is used for determining the level

- Differences between CPT and CMS

Prolonged Services Time – 2021 CPT®

Total Duration of New Patient Office or Other Outpatient Services (use with 99205)	Code(s)
Less than 75 minutes	Not reported separately
75-89 minutes	99205 x 1, 99417 x 1
90-104 minutes	99205 x 1, 99417 x 2
105 minutes or more	99205 x 1, 99417 x 3 or more for each additional 15 minutes

Prolonged Services Time – 2021 CPT®21 CPT

Total Duration of Established Patient Office or Other Outpatient Services (use with 99215)	Code(s)
Less than 55 minutes	Not reported separately
55-69 minutes	99215 x 1, 99417 x 1
70-84 minutes	99215 x 1, 99417 x 2
85 minutes or more	99215 x 1, 99417 x 3 or more for each additional 15 minutes

Prolonged Services Time – CMS

Total Duration of New Patient Office or Other Outpatient Services (use with 99205)	Code(s)
60-74 minutes	99205
89-103 minutes	99205 x 1, G2212 x 1
104-118 minutes	99205 x 1, G2212 x 2
119 minutes or more	99205 x 1, G2212 x 3 or more for each additional 15 minutes

Prolonged Services Time - CMS

Total Duration of Established Patient Office or Other Outpatient Services (use with 99215)	Code(s)
40-54 minutes	99215
69-83 minutes	99215 x 1, G2212 x 1
84-98 minutes	99215 x 1, G2212 x 2
99 minutes or more	99215 x 1, G2212 x 3 or more for each additional 15 minutes

Elements of Medical Decision Making (MDM)

1. Number and Complexity of Problems Addressed at the Encounter
2. Amount and/or Complexity of Data to be Reviewed and Analyzed
3. Risk of Complications and/or Morbidity of Patient Management

- Two of the three elements of MDM must be met or exceeded

MDM Element:
Number and Complexity of Problems Addressed

Number/Complexity of Problems Addressed - **Nature of Presenting Problem**	
Minimal	☐ 1 Self-limited or minor problem
Low	☐ 2+ Self-limited or minor problems ☐ 1 Stable chronic illness ☐ 1 Acute uncomplicated illness/injury
Moderate	☐ 1+ Chronic illness w/ exacerbation, progression, or treatment side effects
	☐ 2+ Stable chronic illness
	☐ Undiagnosed problem w/ uncertain prognosis
	☐ Acute illness w/ systemic symptoms
	☐ Acute complicated injury
High	☐ Chronic illness w/ severe exacerbation, progression, or treatment side effects
	☐ Acute/chronic illness/injury that poses threat to life or bodily function

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Number and Complexity of Problems Addressed at the Encounter

One element used in selecting the level of office or other outpatient services is the number and complexity of the problems that are addressed at an encounter. Multiple new or established conditions may be addressed at the same time and may affect MDM. Symptoms may cluster around a specific diagnosis and each symptom is not necessarily a unique condition. Comorbidities/underlying diseases, in and of themselves, are not considered in selecting a level of E/M services unless they are addressed, and their presence increases the amount and/or complexity of data to be reviewed and analyzed or the risk of complications and/or morbidity or mortality of patient management. The final diagnosis for a condition does not, in and of itself, determine the complexity or risk, as extensive evaluation may be required to reach the conclusion that the signs or symptoms do not represent a highly morbid condition. Therefore, presenting symptoms that are likely to represent a highly morbid condition may "drive" MDM even when the ultimate diagnosis is not highly morbid. The evaluation and/or treatment should be consistent with the likely nature of the condition. Multiple problems of a lower severity may, in the aggregate, create higher risk due to interaction.

The term "risk" as used in these definitions relates to risk from the condition. While condition risk and management risk may often correlate, the risk from the condition is distinct from the risk of the management.

Technical Correction:
Number and Complexity of Problems Addressed at the Encounter

One element used in selecting the level of office or other outpatient services is the number and complexity of the problems that are addressed at an encounter. Multiple new or established conditions may be addressed at the same time and may affect MDM. Symptoms may cluster around a specific diagnosis and each symptom is not necessarily a unique condition. Comorbidities/underlying diseases, in and of themselves, are not considered in selecting a level of E/M services unless they are addressed, and their presence increases the amount and/or complexity of data to be reviewed and analyzed or the risk of complications and/or morbidity or mortality of patient management. The final diagnosis for a condition does not, in and of itself, determine the complexity or risk, as extensive evaluation may be required to reach the conclusion that the signs or symptoms do not represent a highly morbid condition. Therefore, presenting symptoms that are likely to represent a highly morbid condition may "drive" MDM even when the ultimate diagnosis is not highly morbid. The evaluation and/or treatment should be consistent with the likely nature of the condition. Multiple problems of a lower severity may, in the aggregate, create higher risk due to interaction.

The term "risk" as used in these definitions relates to risk from the condition. While condition risk and management risk may often correlate, the risk from the condition is distinct from the risk of the management.

Number and Complexity of Problems Addressed at the Encounter

"Problem Addressed: A problem is addressed or managed when it is evaluated or treated at the encounter by the physician or other qualified health care professional reporting the service. This includes consideration of further testing or treatment that may not be elected by virtue of risk/benefit analysis or patient/parent/guardian/surrogate choice. Notation in the patient's medical record that another professional is managing the problem without additional assessment or care coordination documented does not qualify as being 'addressed' or managed by the physician or other qualified health care professional reporting the service. Referral without evaluation (by history, exam, or diagnostic study[ies]) or consideration of treatment does not qualify as being addressed or managed by the physician or other qualified health care professional reporting the service."

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Number and Complexity of Problems Addressed at the Encounter - Example

Plan:

1. AC joint sprain

Start Vicodin tablet, 500 mg, 1-2 tab(s), orally, Q4-6h as needed for pain, Refills 0.

Imaging: X-ray: Shoulder, right, complete, min 2 view. Grade 2 AC sprain

Placed in sling for AC joint, reviewed gentle ROM exercises as tolerated, will need referral to PT. Per patient, has an orthopedist at home and will set up an appointment. Take Vicodin prn pain. Patient agrees with plan, leaving tomorrow, given copy of X-ray. Follow up with additional concerns.

Number and Complexity of Problems Addressed at the Encounter - Example

2. Thumb sprain

Imaging: X-ray: Fingers, left, min 2 view.

Patient Instructions: Patient appears to have avulsion fracture, UCL, left thumb, laxity noted.

3. Fall from skis

Imaging: X-ray: Fingers, left min 2 views. X-ray: Shoulder, right, complete, min 2 views.

Disposition and Communication:

Follow-up: Next week with Orthopedics

Electronically signed by Robert Smith, MD on 1/5/20XX at 09:33 AM

MDM Element:
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Number and Complexity of Problems Addressed at the Encounter

- Common Documentation Deficiencies
  - Complexity not clear in the documentation
  - Unclear if the provider is addressing the condition
  - Understanding the complexity of the interaction of multiple conditions that the patient has

MDM Element:
Number and Complexity of Data to be Reviewed and Analyzed

Category 1

- ☐ QTY:____ Review of prior external note(s) from each unique source
- ☐ QTY:____ Review of the result(s) of each unique test
- ☐ QTY:____ Ordering of each unique test

Independent Historian (IH) (Category 2 for Limited; Category 1 for Moderate/High)

- ☐ Assessment requiring independent historian(s)

Category 2

- ☐ Independent interpretation of a test performed by another physician/other QHP (not separately reported)

Category 3

- ☐ Discussion of management or test interpretation with external physician/other QHP/appropriate source (not separately reported)

Total	0 or 1	1 of 2	1 of 3	2 of 3
	☐ 1-Category 1 or less	☐ 2-Category 1 ☐ IH	☐ 3-Category 1/IH ☐ 1-Category 2 ☐ 1-Category 3	☐ 3-Category 1/IH ☐ 1-Category 2 ☐ 1-Category 3
Data Level	Minimal or None	Limited	Moderate	Extensive

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Data Level	Minimal or None	Limited	Moderate	Extensive

External Records

External records, communications and/or test results are from an external physician, other qualified health care professional, facility or healthcare organization.

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	☐ 1-Category 1 or less	☐ 2-Category 1 ☐ IH	☐ 3-Category 1/IH ☐ 1-Category 2 ☐ 1-Category 3	☐ 3-Category 1/IH ☐ 1-Category 2 ☐ 1-Category 3
Data Level	Minimal or None	Limited	Moderate	Extensive

Technical Correction: Services Reported Separately

The ordering and actual performance and/or interpretation of diagnostic tests/studies during a patient encounter are not included in determining the levels of E/M services when the professional interpretation of those tests/studies is reported separately by the physician or other qualified health care professional reporting the E/M service. Tests that do not require separate interpretation (eg, tests that are results only) and are analyzed as part of MDM do not count as an independent interpretation but may be counted as ordered or reviewed for selecting an MDM level.

Example

CHIEF COMPLAINT: Established patient, sore throat. Patient is being seen for a sore throat. Patient states that her throat started hurting on 8/1/20XX. Patient has nasal drainage down the back of her throat and her nose.

HPI: 26 y/o female c/o sore throat x 3 days. + bilateral ear pain + runny nose + postnasal drainage. Denies cough, fever, chills. Works at a daycare.

VITALS: Height: 5’5”. Weight: 213 lbs. BMI: 35.4. BP: 136/88 sitting L arm. Pulse: 92 bpm. RR: 18. T: 99.3 F°.

ROS: Patient reports ear pain (BIL) and sore throat but reports no ear discharge, no hearing loss, no sinus pressure, no drooling, no facial swelling, no congestion, no hoarseness, and no mouth lesions. She reports sneezing and runny nose.

PHYSICAL EXAM: Patient is a 26-year-old female.

ENMT: Ears: no hearing loss, canals clear, and TM landmarks clear. Nose: no erythema, edema, sinus tenderness, or septal deviation and nares patent. Oral Cavity: moist mucous membranes and normal dentition. Pharynx: erythema, exudates, and tonsils enlarged.

LYMPH NODES: LAD.

LUNGS: Auscultation: no rales/crackles, rhonchi, or wheezing and clear to auscultation. CARDIOVASCULAR: Rate and Rhythm RRR. Heart sounds normal S1 and S2 and no murmurs.

RESULTS/INTERPRETATIONS: Rapid Strep A done in office today is negative.

ASSESSMENT/PLAN: 1. ACUTE TONSILLITIS. AUGMENTIN 875 MG TAB.

RETURN TO OFFICE: None recorded.

Technical Correction: Analyzed

Analyzed: the process of using the data as part of the MDM. The data element itself may not be subject to analysis (eg, glucose), but it is instead included in the thought processes for diagnosis, evaluation, or treatment. Tests ordered are presumed to be analyzed when the results are reported. Therefore, when they are ordered during an encounter, they are counted in that encounter. Tests that are ordered outside of an encounter may be counted in the encounter in which they are analyzed. In the case of a recurring order, each new result may be counted in the encounter in which it is analyzed. For example, an encounter that includes an order for monthly prothrombin times would count for one prothrombin time ordered and reviewed. Additional future results, if analyzed in a subsequent encounter, may be counted as a single test in that subsequent encounter. Any service for which the professional component is separately reported by the physician or other qualified health care professional reporting the E/M services is not counted as a data element ordered, reviewed, analyzed, or independently interpreted for the purposes of determining the level of MDM.

Example

DIAGNOSTIC DATA: UA dipstick, performed in office today. Yellow color, glucose negative, bilirubin negative, large ketones, specific gravity 1.015, trace non-hemolyzed blood, pH 6.5, albumin negative, urobilinogen normal, nitrate negative, leukocytes negative.

ASSESSMENT AND PLAN: Fever, persistent with vomiting and diarrhea. Will check urinalysis and consider doing further blood work and stool workup if urine normal. Will give a dose of Zofran in clinic. Change formula to Alimentum to alleviate the temporary lactose intolerance caused by the diarrhea. Continue to give Pedialyte if not taking formula. Further management to depend on test results. Urinalysis normal except for ketones (no glucose) which is caused by the current anabolic state. Recheck on Monday or Tuesday next week, sooner if worse. Ordered BMP, CBC with differential, stool culture, stool O&P, urine culture.

Technical Correction: Test

Test: Tests are imaging, laboratory, psychometric, or physiologic data. A clinical laboratory panel (eg, basic metabolic panel [80047]) is a single test. The differentiation between single or multiple ~~unique~~ tests is defined in accordance with the CPT code set. For the purposes of data reviewed and analyzed, pulse oximetry is not a test.

Technical Correction: Unique Test

Unique: A unique test is defined by the CPT code set. When multiple results of the same unique test (eg, serial blood glucose values) are compared during an E/M service, count it as one unique test.

Tests that have overlapping elements are not unique, even if they are identified with distinct CPT codes. For example, a CBC with differential would incorporate the set of hemoglobin, CBC without

differential, and platelet count. A unique source is defined as a physician or qualified heath care professional in a distinct group or different specialty or subspecialty, or a unique entity. Review of all materials from any unique source counts as one element toward MDM.

Example

Lab Results

Test	Value	Date
A1C	9.2*	1/14/20X4
A1C	7.4*	7/25/20X3
A1C	7.7*	10/29/20X2
A1C	6.5*	1/12/20X1

Lipids

Test	Value	Date
TRIG	299*	1/14/20X4
CHOL	214*	1/14/20X4
HDL	30*	1/14/20X4
LDL	124	1/14/20X4

Example

CHIEF COMPLAINT: She is here for echocardiogram results.

INTERVAL HISTORY: The patient presents today for echocardiogram results. Overall, she feels she is better. Her oxygen is at 3 liters per nasal cannula most of the time but increases to 6 liters a minute with walking upstairs or other heavier exercise. Her home blood pressure is 120/82. She has had no chest pain, no syncopal episodes, and no major illnesses or hospitalizations.

Echocardiogram shows:
1. Ejection fraction of 70-80%
2. Moderate to severe pulmonary insufficiency.
3. Mild to moderate tricuspid regurgitation.
4. Mild to moderate mitral regurgitation.
5. Mild aortic valve stenosis.
6. Mild to moderate left ventricular hypertrophy.
7. Hyperdynamic left ventricle.
8. Mild to moderate pulmonary hypertension at 45 mmHg, which is a significant improvement from previous echocardiogram.

PHYSICAL EXAM
VITAL SIGNS: Weight 107 1k, BP 112/68 in the left arm, pulse 73 and regular. Oxygen saturation 95% on room air.
CONSTITUTIONAL: In no acute distress.
HEENT: Eyes: No xanthelasma or exophthalmos. No arcus senilis. Tongue midline. Mucous membranes moist, with no cyanosis.
RESPIRATORY: Respirations even and unlabored. Good air entry bilaterally. No adventitious sounds. Chest has normal contour.
CARDIOVASCULAR: There is a 1+ sternal lift. 1 is normal. S2 is increased. There is a grade 3/6 long pansystolic murmur at the apex, radiating well out to the axilla and to the left sternal edge. No diastolic murmur appreciated. No S3 gallop evident
GASTROINTESTINAL: Abdomen: Soft. Positive BS x4 quads. No masses or tenderness. No hepatosplenomegaly.
SKIN: Pink, warm and dry. Skin intact. No rashes. No lesions. No clubbing or cyanosis.
NEUROLOGIC/PSYCH: Cranial nerves II-XII grossly intact. A&03. Affect normal.

ASSESSMENT
1. Improved pulmonary hypertension on Revatio and Letairis.
2. Normally functioning pacemaker.
3. Blood pressure well controlled.

PLAN
1. She is to continue, as above.
2. Echo and office visit in six months.

Technical Correction: Combination of Data Elements

Combination of Data Elements: A combination of different data elements, for example, a combination of notes reviewed, tests ordered, tests reviewed, or independent historian, allows these elements to be summed. It does not require each item type or category to be represented. A unique test ordered, plus a note reviewed and an independent historian would be a combination of three elements.

Example

SUBJECTIVE: Patient was recently hospitalized. We do have the medical records from the hospital after suffering a seizure. During that time she recurrently experienced bleeding from her ears, her nose, and coughing up blood. She was discharged on Keppra 1000 mg 1 b.i.d. and Ativan 0.5 mg 1 t.i.d. She has had no seizures since leaving the hospital and no recurrence of any hemoptysis, epistaxis or bleeding from her ears. Her EEG in the hospital revealed nonepileptic seizure activity, and her MRI scan was normal except for solitary area nonspecific in her posterior left frontal lobe. Her mother was with her today, and they have given me some more history. First of all, this patient is seeing a hematologist and evaluated for coagulopathy. She has also been seen by an ENT doctor, and in the past she has been seen and evaluated by a neurologist and other specialists. Her history of recurrent seizures and bleeding have been occurring for several years now. We had asked her to get the medical records, and she did get some records from 20XX, 20XX, and 20XX, but those are really not what we need. We need the medical records regarding these evaluations that have been done so we can determine where we need to go from here. No one has ever been able to figure out why she bleeds from her ears, and she cannot differentiate whether she is vomiting blood or coughing it up. When she has a seizure she loses awareness. She has bitten her tongue. She has amnesia around the episodes. She has jerking movements. There is no history of any neurological deficits.

Example

SUBJECTIVE: Patient was recently hospitalized. We do have the medical records from the hospital after suffering a seizure. During that time she recurrently experienced bleeding from her ears, her nose, and coughing up blood. She was discharged on Keppra 1000 mg 1 b.i.d. and Ativan 0.5 mg 1 t.i.d. She has had no seizures since leaving the hospital and no recurrence of any hemoptysis, epistaxis or bleeding from her ears. Her EEG in the hospital revealed nonepileptic seizure activity, and her MRI scan was normal except for solitary area nonspecific in her posterior left frontal lobe. Her mother was with her today, and they have given me some more history. First of all, this patient is seeing a hematologist and evaluated for coagulopathy. She has also been seen by an ENT doctor, and in the past she has been seen and evaluated by a neurologist and other specialists. Her history of recurrent seizures and bleeding have been occurring for several years now. We had asked her to get the medical records, and she did get some records from 20XX, 20XX, and 20XX, but those are really not what we need. We need the medical records regarding these evaluations that have been done so we can determine where we need to go from here. No one has ever been able to figure out why she bleeds from her ears, and she cannot differentiate whether she is vomiting blood or coughing it up. When she has a seizure she loses awareness. She has bitten her tongue. She has amnesia around the episodes. She has jerking movements. There is no history of any neurological deficits.

MDM Element:
Number and Complexity of Data to be Reviewed and Analyzed

Category 1

- ☐ QTY:____ Review of prior external note(s) from each unique source
- ☐ QTY:____ Review of the result(s) of each unique test
- ☐ QTY:____ Ordering of each unique test

Independent Historian (IH) (Category 2 for Limited; Category 1 for Moderate/High)

- ☐ Assessment requiring independent historian(s)

Category 2

- ☐ Independent interpretation of a test performed by another physician/other QHP (not separately reported)

Category 3

- ☐ Discussion of management or test interpretation with external physician/other QHP/appropriate source (not separately reported)

Total	0 or 1	1 of 2	1 of 3	2 of 3
	☐ 1-Category 1 or less	☐ 2-Category 1 ☐ IH	☐ 3-Category 1/IH ☐ 1-Category 2 ☐ 1-Category 3	☐ 3-Category 1/IH ☐ 1-Category 2 ☐ 1-Category 3
Data Level	Minimal or None	Limited	Moderate	Extensive

Technical Correction: Independent Historian

Independent historian(s): An individual (eg, parent, guardian, surrogate, spouse, witness) who provides a history in addition to a history provided by the patient who is unable to provide a complete or reliable history (eg, due to developmental stage, dementia, or psychosis) or because a confirmatory history is judged to be necessary. In the case where there may be conflict or poor communication between multiple historians and more than one historian is needed, the independent historian requirement is met. The independent history does not need to be obtained in person but does need to be obtained directly from the historian providing the independent information.

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Number and Complexity of Data to be Reviewed and Analyzed

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- ☐ QTY:____ Review of the result(s) of each unique test
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Data Level	Minimal or None	Limited	Moderate	Extensive

Independent Interpretation

The interpretation of a test for which there is a CPT code and an interpretation or report is customary. This does not apply when the physician or other qualified health care professional is reporting the service or has previously reported the service for the patient. A form of interpretation should be documented, but need not conform to the usual standards of a complete report for the test.

MDM Element:
Number and Complexity of Data to be Reviewed and Analyzed

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- ☐ QTY:____ Review of prior external note(s) from each unique source
- ☐ QTY:____ Review of the result(s) of each unique test
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Data Level	Minimal or None	Limited	Moderate	Extensive

Technical Correction: Discussion

Discussion: Discussion requires an interactive exchange. The exchange must be direct and not through intermediaries (eg, clinical staff or trainees). Sending chart notes or written exchanges that are within progress notes does not qualify as an interactive exchange. The discussion does not need to be on the date of the encounter, but it is counted only once and only when it is used in the decision making of the encounter. It may be asynchronous (ie, does not need to be in person), but it must be initiated and completed within a short time period (eg, within a day or two).

Example:

P:

1) I will restart the patient on Depo-Provera as this was clearly helping her approximately 12 months ago. She was given the options and brief counseling regarding surgical management of this. Her goal is to stay out of the operating room at this time.

2) Left breast mass. I will refer her to general surgery. I have spoken briefly with Dr. B regarding this. She will likely need a mammogram and probably an ultrasound of this area. Unfortunately, this will probably require an authorization.

3) She is to follow up with me in 12 months or sooner if her pelvic pain is not improved on the Depo-Provera.

MDM Element:
Number and Complexity of Data to be Reviewed and Analyzed

Category 1

- ☐ QTY:____ Review of prior external note(s) from each unique source
- ☐ QTY:____ Review of the result(s) of each unique test
- ☐ QTY:____ Ordering of each unique test

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Data Level	Minimal or None	Limited	Moderate	Extensive

External physician or other qualified healthcare professional

An external physician or other qualified health care professional is an individual who is not in the same group practice or is a different specialty or subspecialty. It includes licensed professionals that are practicing independently. It may also be a facility or organizational provider such as a hospital, nursing facility, or home health care agency.

Amount and/or Complexity of Data to be Reviewed and Analyzed

- Common Documentation Deficiencies
  - Unclear number of tests ordered
  - Unclear if the information in the history is from a current test reviewed or restating historical information
  - Unclear if the provider performed an interpretation and billed for it or is performing a review
  - When children are brought in by parent(s), it is not documented if the parent is providing the history

Amount and/or Complexity of Data to be Reviewed and Analyzed

- Common Questions
  - If a provider orders and performs a test in the office, does that count as two for data? One for ordering and one for reviewing the results?
  - Does a parent always qualify for an independent historian for pediatric patients?

Amount and/or Complexity of Data to be Reviewed and Analyzed- Example

VASCULAR STUDIES: Duplex examination of right carotid artery on 03/17/xx reveals 50-60% stenosis right internal carotid artery.

A: Per ultrasound increase from 30% to 50-60% stenosis which is asymptomatic.

P: I would like to get a MRA of the neck and see the pt back in one week to review results.

Amount and/or Complexity of Data to be Reviewed and Analyzed- Example

VASCULAR STUDIES: Duplex examination of right carotid artery on 03/17/xx reveals 50-60% stenosis right internal carotid artery.

A: Per ultrasound increase from 30% to 50-60% stenosis which is asymptomatic.

P: I would like to get a MRA of the neck and see the pt back in one week to review results.

MDM Element:
Risk of Complications and/or Morbidity or Mortality of Patient Management

Risk of Complications and/or Morbidity or Mortality of Patient Management	
Minimal	❑ Minimal risk of morbidity from additional diagnostic testing or treatment
	Examples:
	Rest, gargles, elastic bandages, superficial dressings
Low	❑ Low risk of morbidity from additional diagnostic testing or treatment
	Examples:
	OTC drugs, minor surgery w/o identified risk factors, PT/OT therapy, IV fluids w/o additives
Moderate	❑ Moderate risk of morbidity from additional diagnostic testing or treatment
	Examples:
	Prescription drug management
	Decision regarding minor surgery w/ identified patient or Tx risk factors
	Decision regarding elective major surgery w/o identified PT or Tx risk factors
	Diagnosis or Tx significantly limited by social determinants of health
High	❑ High risk of morbidity from additional diagnostic testing or treatment
	Examples:
	Drug therapy requiring intensive monitoring for toxicity
	Decision regarding elective major surgery w/ identified patient or treatment risk factors
	Decision regarding emergency major surgery
	Decision regarding hospitalization
	Decision not to resuscitate or to de-escalate care because of poor prognosis

Technical Correction: Risk

One element used in selecting the level of service is the risk of complications and/or morbidity or mortality of patient management at an encounter. This is distinct from the risk of the condition itself.

Risk

The probability and/or consequences of an event. The assessment of the level of risk is affected by the nature of the event under consideration. Level of risk is based upon consequences of the problem(s) addressed at the encounter when appropriately treated. Risk also includes medical decision making related to the need to initiate or forego further testing, treatment and/or hospitalization.

Technical Correction: Surgery

- Surgery—Minor or Major: The classification of surgery into minor or major is based on the common meaning of such terms when used by trained clinicians, similar to the use of the term “risk.” These terms are not defined by a surgical package classification.
- Surgery—Elective or Emergency: Elective procedures and emergent or urgent procedures describe the timing of a procedure when the timing is related to the patient’s condition. An elective procedure is typically planned in advance (eg, scheduled for weeks later), while an emergent procedure is typically performed immediately or with minimal delay to allow for patient stabilization. Both elective and emergent procedures may be minor or major procedures.
- Surgery—Risk Factors, Patient or Procedure: Risk factors are those that are relevant to the patient and procedure. Evidence-based risk calculators may be used, but are not required, in assessing patient and procedure risk.

MDM Element:
Risk of Complications and/or Morbidity or Mortality of Patient Management

Risk of Complications and/or Morbidity or Mortality of Patient Management	
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	Decision regarding elective major surgery w/ identified patient or treatment risk factors
	Decision regarding emergency major surgery
	Decision regarding hospitalization
	Decision not to resuscitate or to de-escalate care because of poor prognosis

Social determinants of health

- Economic and social conditions that influence the health of people and communities. Examples may include food or housing insecurity.
- ICD-10-CM codes Z55- Z65

MDM Element:
Risk of Complications and/or Morbidity or Mortality of Patient Management

Risk of Complications and/or Morbidity or Mortality of Patient Management	
Minimal	❑ Minimal risk of morbidity from additional diagnostic testing or treatment
	Examples:
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	OTC drugs, minor surgery w/o identified risk factors, PT/OT therapy, IV fluids w/o additives
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	Examples:
	Prescription drug management
	Decision regarding minor surgery w/ identified patient or Tx risk factors
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	Drug therapy requiring intensive monitoring for toxicity
	Decision regarding elective major surgery w/ identified patient or treatment risk factors
	Decision regarding emergency major surgery
	Decision regarding hospitalization
	Decision not to resuscitate or to de-escalate care because of poor prognosis

Drug therapy requiring intensive monitoring for toxicity

- Adverse effects not therapeutic efficacy
- Generally accepted practice for the agent, but may be patient specific in some cases
- Long-term or short term
- Long-term intensive monitoring is not less than quarterly
- Monitoring: lab test, a physiologic test or imaging. Not history or exam

Risk of Complications and/or Morbidity or Mortality of Patient Management

- Common Documentation Deficiencies
  - Unclear if the provider is managing the prescription or another provider
  - Documentation lacks all treatment options discussed
  - Documentation lacks a plan for each diagnosis
  - When a patient has a social determinant, it is not always clear if the patient's condition is significantly limited

Risk of Complications and/or Morbidity or Mortality of Patient Management

- Common Questions
  - All surgery has a risk, when would it qualify for “identified patient or procedure risk factors?”
  - What if the treatment options for the patient encounter is not included as one of the examples?

Medical Necessity

Required regardless of the guideline changes

Sources

- AMA website: https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf
- The technical corrections can be found on the AMA website https://www.ama-assn.org/practice-management/cpt/errata-technical-corrections
- 2021 CPT code book
- CMS 2021 Final Rule: https://www.cms.gov/medicaremedicare-fee-service-paymentphysicianfeeschedpfs-federal-regulation-notices/cms-1734-f

Risk Adjustment

Proper Documentation for ICD-10-CM

False Claims Legal Actions

Government Intervenes in False Claims Act Lawsuits Against Kaiser Permanente Affiliates for Submitting Inaccurate Diagnosis Codes to the Medicare Advantage Program

Medicare requires that, for outpatient medical encounters, MA Plans submit diagnoses to CMS only for conditions that required or affected patient care, treatment or management during an in-person encounter in the service year. In order to increase its Medicare reimbursements, Kaiser allegedly pressured its physicians to create addenda to medical records after the patient encounter, often months or over a year later, to add risk-adjusting diagnoses that patients did not actually have and/or were not actually considered or addressed during the encounter, in violation of Medicare requirements.

Source: https://www.justice.gov/opa/pr/government-intervenes-false-claims-act-lawsuits-against-kaiser-permanente-affiliates

Health Care Fraud and Abuse Control Program FY 2020

HHS-OIG is also strengthening oversight of managed care in the Medicare Advantage (MA), Medicaid managed care programs, new value-based models, and technology and cybersecurity.

Source: https://www.justice.gov/criminal-fraud/file/1411906/download

HHS-OIG Audits and Evaluations

Billions in Estimated Medicare Advantage Payments From Diagnoses Reported Only on Health Risk Assessments Raise Concerns. Billions of estimated MA risk-adjusted payments supported solely through health risk assessments (HRAs) raise concerns about the completeness of payment data submitted to CMS, the validity of diagnoses on HRAs, and the quality of care coordination for beneficiaries. Diagnoses that MA organizations reported only on HRAs—and on no other encounter records in 2016—resulted in an estimated $2.6 billion in risk adjusted payments for 2017. In addition, in-home HRAs generated 80 percent of these estimated payments. Most in-home HRAs were conducted by companies that partner with or are hired by MA organizations to conduct these assessments—and therefore are not likely conducted by the beneficiary's own primary care provider. 20 MA organizations generated millions in payments from in-home HRAs for beneficiaries for whom there was not a single record of any other service being provided in 2016. (OEI-03-17-00471).

HHS-OIG Audits and Evaluations

Billions in Estimated Medicare Advantage Payments From Chart Reviews Raise Concerns. Billions of estimated MA risk-adjusted payments supported solely through chart reviews raise potential concerns about the completeness of payment data submitted to CMS, the validity of diagnoses on chart reviews, and the quality of care provided to beneficiaries. Diagnoses that MA organizations reported only on chart reviews—and not on any service records—resulted in an estimated $6.7 billion in risk-adjusted payments for 2017. CMS based an estimated $2.7 billion in risk-adjusted payments on chart review diagnoses that MA organizations did not link to a specific service provided to the beneficiary. Although limited to a small number of beneficiaries, almost half of MA organizations reviewed had payments from unlinked chart reviews where there was not a single record of a service being provided to the beneficiary in all of 2016. (OEI03-17- 00470)

OIG Work Plan

Medicare Advantage Risk-Adjustment Data - Targeted Review of Documentation Supporting Specific Diagnosis Codes

Payments to Medicare Advantage (MA) organizations are risk-adjusted on the basis of the health status of each beneficiary. MA organizations are required to submit risk-adjustment data to CMS in accordance with CMS instructions (42 CFR § 422.310(b)), and inaccurate diagnoses may cause CMS to pay MA organizations improper amounts (SSA §§ 1853(a)(1)(C) and (a)(3)). In general, MA organizations receive higher payments for sicker patients. CMS estimates that 9.5 percent of payments to MA organizations are improper, mainly due to unsupported diagnoses submitted by MA organizations. Prior OIG reviews have shown that some diagnoses are more at risk than others to be unsupported by medical record documentation. We will perform a targeted review of these diagnoses and will review the medical record documentation to ensure that it supports the diagnoses that MA organizations submitted to CMS for use in CMS's risk score calculations and determine whether the diagnoses submitted complied with Federal requirements.

Source: https://oig.hhs.gov/reports-and-publications/workplan/summary/wp-summary-0000422.asp

Diagnosis Code Selection

Common concerns

- Documentation
- Thorough code selection
  - Pick-lists
  - Superbill/encounter form
- ICD-10-CM coding guidelines
  - Instructions for reporting ICD-10-CM codes
  - Provider feedback
  - Accurately report all current diagnoses for a complete clinical profile
- Reporting period: January-December

Diagnosis Code Selection

Medicare Advantage Organizations (MAOs)

- Conservative Approach
- Code all face-to-face encounters
  - Hospital Inpatient
  - Hospital Outpatient
  - Physician Services
- Do not collect diagnoses from
  - Radiological or other diagnostic test orders or reports
  - Laboratory requests or results (except pathology)
- Do not confuse with E/M coding guidelines

Chronic and other additional diagnoses

Contract-Level RADV Medical Record Reviewer Guidance

- Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s) (Section IV, I)

- Code all documented conditions that coexist at the time of the encounter/visit and require or affect patient care treatment or management. (Section IV, J)

Chronic and other additional diagnoses

Section IV. Diagnostic Coding and Reporting Guidelines for Outpatient Services

I. Chronic diseases

Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s)

Chronic and other additional diagnoses

Section IV. Diagnostic Coding and Reporting Guidelines for Outpatient Services

J. Code all documented conditions that co-exist

Code all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care treatment or management. Do not code conditions that were previously treated and no longer exist. However, history codes (categories Z80-Z87) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.

Chronic and other additional diagnoses

Section III. Reporting Additional Diagnoses
General Rules for Other (Additional) Diagnoses

For reporting purposes, the definition for “other diagnoses” is interpreted as additional conditions that affect patient care in terms of requiring:

- clinical evaluation; or
- therapeutic treatment; or
- diagnostic procedures; or
- extended length of hospital stay; or
- increased nursing care and/or monitoring.

Chronic and other additional diagnoses

AHA Coding Clinic for ICD-9-CM © 3rd Qtr, 2007, p. 13–14*

Question: We need to get clarification on the coding of chronic conditions. One of the quality improvement organizations (QIOs) will not allow the inclusion of chronic obstructive pulmonary disease (COPD) as a secondary diagnosis when it is only mentioned as a history of COPD and no active treatment is documented. Am I correct in stating the presence of a documented history of COPD in the physician's history and physical on an inpatient record is enough to code COPD as a secondary diagnosis since this is a chronic condition that always affects the patient's care and treatment to some extent?

Chronic and other additional diagnoses

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Answer: As stated in Coding Clinic, July–August 1985, page 10, the criteria for selection of the conditions to be reported as “other diagnoses” include the severity of the condition, use or consideration of alternative measures in the treatment of the principal diagnosis due to a coexisting condition, increased nursing care required in the care of patients due to the disabling features of the coexisting condition, use of diagnostic or therapeutic services for the particular coexisting condition, the need for close monitoring of medications, or modifications of nursing care plans. If there is documentation in the medical record to indicate the patient has COPD, it should be coded. Even if this condition is listed only in the history section with no contradictory information, the condition should be coded. Chronic conditions such as, but not limited to, hypertension, Parkinson's disease, COPD, and diabetes mellitus are chronic systemic diseases that ordinarily should be coded even in the absence of documented intervention or further evaluation. Some chronic conditions affect the patient for the rest of his or her life and almost always require some form of continuous clinical evaluation or monitoring during hospitalization, and therefore should be coded. This advice applies to inpatient coding. The following guidelines are to be applied in designating “other diagnoses” for both inpatient and outpatient when neither the Alphabetic Index nor the Tabular List in ICD-9-CM provides direction. The listing of the diagnoses in the patient record is the responsibility of the attending provider.

Chronic and other additional diagnoses

- **M**onitor
- **E**valuate
- **A**ssess
- **T**reat

Example

CHIEF COMPLAINT: Reflux.

HISTORY OF PRESENT ILLNESS: This is a 36-year-old woman who has a 10-year history of reflux starting after her burn and inhalation injury in 1999. She described her symptoms as a burning sensation behind her breast bone that is worsened with spicy food and lying down. The patient has been on Nexium for a long time but it stopped working seven or eight months ago. She was then placed on Kapidex and ranitidine since then. Even with these two medications, she still has some symptoms. She has to be very careful about the foods that she eats. Her lifestyle is significantly affected by this problem. She denies any trouble swallowing or early satiety.

The patient also suffers from laryngeal stenosis from her inhalation injuries and has been operated on four times. The last time which was last month by Dr. Her reflux might be contributing to this problem as well.

The patient has had significant weight gain in the last few years, most likely related to her sedentary lifestyle because she cannot exercise due to her laryngeal stenosis. After the last surgery, which she was able to breath better and move around, she lost 8-9 pounds.

Example

PAST MEDICAL HISTORY:

1. History of burn.
2. Laryngeal stenosis as mentioned above.
3. Hypertension.
4. Diabetes being treated with metformin. Her glucose level is around 100.
5. Depression.

PAST SURGICAL HISTORY:

1. Multiple skin grafts.
2. Multiple laryngeal surgeries for laryngeal stenosis.
3. Laparoscopic cholecystectomy.
4. Laparoscopic ovarian cystectomy.

MEDICATIONS: Kapidex, ranitidine, fluoxetine, metformin, simvastatin, and metoprolol.

Example

ALLERGIES: Morphine which causes rash, codeine which causes rash, and erythromycin which causes whole body rash.

FAMILY HISTORY: Significant for high blood pressure in her paternal uncle and diabetes in her mother.

SOCIAL HISTORY: The patient is married. She is a pharmacy tech but currently is unemployed. She denies any tobacco or alcohol use.

REVIEW OF SYSTEMS: A 14 point review of systems was performed and all of the significant positives were included in the HPI and past medical history.

Example

PHYSICAL EXAMINATION:

GENERAL: Well-appearing, NAD. The patient is morbidly obese. VITAL SIGNS: T: 97.6? BP: 149/116 P: 100 R: 15 WT: 254.1 pounds HT: 5 feet 3 inches. HEENT: NC/AT, PERRLA, EOMs intact, sclera non-icteric MOUTH: Mucus membranes and tongue pink, moist without lesions. NECK: Supple, trachea midline, no thyromegaly or adenopathy. CHEST: CTA. HEART: RRR, no gallops, rubs, or murmurs. BACK: No CVA tenderness. ABDOMEN: Soft, non-tender and non-distended, no HSM, no masses/hernias. There was evidence of skin graft in a band like fashion in her epigastric region. GROIN: No hernias, no adenopathy. EXTREMITIES: No cyanosis, clubbing, or edema. RECTAL: Deferred. SKIN: No obvious rashes, petechiae, or lesions. PULSES: 4+ bilateral upper/lower extremity, no carotid or femoral bruits. NEURO: Alert and oriented to person, place, time, and situation; motor and sensory grossly intact.

RADIOGRAPHIC STUDIES: Reviewed radiology report. She did have a previous BRAVO study that showed a DeMeester score of 27.3. Her esophageal manometry showed impaired motility.

Example

ASSESSMENT/PLAN: This is a 36-year-old woman with a history of burn and laryngeal stenosis as well as severe heartburn that initially responded but then become refractory to medications. She does have objective evidence of reflux as evidenced by her DeMeester score of 27.

We had a long discussion with her with regard to her options. It seems that she is a good surgical candidate based on the fact that she has classical symptoms, her symptom responded to medication initially, and she has objective evidence of reflux. However, she is morbidly obese with a BMI of 45. We explained to her that with a BMI greater than 35, the rate of recurrence goes from 3%-5% up to 30%. However, with her problems from laryngeal stenosis, it is unlikely that she will be able to lose enough weight to get her BMI down to below 35. Therefore, we will plan ahead with the surgery with the understanding that her recurrent rate might be higher.

To complete the problem further, even though she does not have any symptoms of dysphagia, her esophageal manometry was abnormal. Even though the Toupet fundoplication is as effective as the Nissen fundoplication in controlling reflux symptoms, it does have a higher recurrence rate up to 20%. We presented this fact to her and discussed the option of doing a Toupet fundoplication or a short and loose Nissen fundoplication. She would rather have to adjust her diet to avoid dysphagia and then suffering from a higher chance of recurrence. We therefore decided to proceed with a laparoscopic Nissen fundoplication.

We will plan to perform the surgery next week together with Dr. Smith for her laryngeal stenosis.

Diagnosis Code Selection

CMS Risk Adjustment Participant Guide (2008)

6.4.1 Co-Existing and Related Conditions

The instructions for risk adjustment implementation refer to the official coding guidelines for ICD-9-CM, published at www.cdc.gov/nchs/icd9.htm and in the Coding Clinic®. Physicians should code all documented conditions that co-exist at the time of the encounter/visit and require or affect patient care treatment or management. Do not code conditions that were previously treated and no longer exist. However, history codes (V10-V19 not in HCC model) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.

Contract-Level RADV Medical Record Reviewer Guidance

If the provider has included a diagnosis in the final diagnostic statement, such as the discharge summary or the face sheet, it should ordinarily be coded. Some providers include in the diagnostic statement resolved conditions or diagnoses and status-post procedures from previous admission that have no bearing on the current stay. Such conditions are not to be reported and are coded only if required by hospital policy. However, ICD-9-CM personal history codes (codes V10-V19) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment. (Section III, A) [For example, the Official Coding Guidance regarding neoplasms states:
When a primary malignancy has been previously excised or eradicated from its site and there is no further treatment directed to that site and there is no evidence of any existing primary malignancy, a code from category V10, Personal history of malignant neoplasm, should be used to indicate the former site of the malignancy. Any mention of extension, invasion, or metastasis to another site is coded as a secondary malignant neoplasm to that site. The secondary site may be the principal or first-listed with the V10 code used as a secondary. (Section I, C. 2d)]

I.C.2.m. Current malignancy versus personal history of malignancy

When a primary malignancy has been excised but further treatment, such as an additional surgery for the malignancy, radiation therapy or chemotherapy is directed to that site, the primary malignancy code should be used until treatment is completed.

When a primary malignancy has been previously excised or eradicated from its site, there is no further treatment (of the malignancy) directed to that site, and there is no evidence of any existing primary malignancy at that site, a code from category Z85, Personal history of malignant neoplasm, should be used to indicate the former site of the malignancy.

Codes from subcategories Z85.0 – Z85.85 should only be assigned for the former site of a primary malignancy, not the site of a secondary malignancy. Code Z85.89 may be assigned for the former site(s) of either a primary or secondary malignancy.

See Section I.C.21. Factors influencing health status and contact with health services, History (of)

History vs. Active Cancer

- Current
  - Active treatment for the purpose of palliating or curing cancer
  - Cancer is present but unresponsive to treatment
  - Patient refused treatment
- In Remission
  - The National Cancer Institute defines in remission as: “A decrease in or disappearance of signs or symptoms of cancer. Partial remission, some but not all signs and symptoms of cancer have disappeared. Complete remission, all signs and symptoms of cancer have disappeared, although cancer still may be in the body.”
  - Coded as current if there is no code for remission.
- History of Cancer
  - History of Cancer
  - Cancer free
  - No evidence of disease

History vs. Active Cancer

CHIEF COMPLAINT: Recurrent ovarian cancer.

HISTORY OF PRESENT ILLNESS: This is a very delightful 69-year-old white female with a history of metastatic stage IV ovarian cancer dating back to December of 20XX. Currently she has completed a round of systemic chemotherapy for recurrence which was Taxotere and carboplatin and she seemed to be having a good response. Her last CA125 level was on December 28, 20XX and it was at 7. She received her final cycle of chemotherapy on December 27, 20XX. She underwent a CT scan of the abdomen and pelvis on January 22, 20XX. She is here today for scan results. She denies any nausea, vomiting, increasing abdominal girth, or any vaginal bleeding. She does feel somewhat tired and run down, but states that when she takes her iron pill and supplements with food, she feels better. Her scan results were reviewed and discussed with the patient.

REVIEW OF SYSTEMS

Neurologic: Neuropathy in her fingers. All others negative.

History vs. Active Cancer

PHYSICAL EXAMINATION: A well-developed 69-year-old white female in no apparent distress.

VITAL SIGNS: Weight 196; BP 150/90; Pulse 88; Pulse ox 97%

Neuro/Psych: Normal orientation, mood and affect with some slight depression, which she denies.

HEENT: Normal.

Neck: Normal, no masses. Trachea midline. No thyromegaly noted.

Respiratory: Lungs clear to auscultate bilaterally.

Cardiovascular: Heart regular rate and rhythm. Normal S1, S2 with no murmurs.

Abdomen: Soft, nondistended, no masses, no tenderness, no hernias, no hepatosplenomegaly.

Lymphatic: Neck and groin nodes negative.

Gynecologic: Deferred.

Extremities: She does have approximately a 1+ pitting edema bilaterally with +2/4 peripheral pulses noted. She does wear support hose on a regular basis.

History vs. Active Cancer

ASSESSMENT: Recurrent ovarian cancer, stage IV.

PLAN

1. Dr. discussed in detail the results of her CT scans which reveal a significant increased size of the pelvic lesions with a new anterior mass noted.
2. After discussion with the client, she has decided that she needs a break and needs to defer further chemotherapy for at least a month.
3. Follow up in one month and at that time CA125 and a CBC will be drawn.

History vs. Active Cancer

April 24, 20XX

Re: Patient

DOB: 11/15/XX

Dear Dr. X:

I saw this patient today in the office for her routine one-year visit. As you know, she has a history of an early-stage cancer of the upper inner quadrant of the left breast. She was T1c, N0, M0, estrogen and progesterone receptor positive breast cancer and she underwent bilateral mastectomy and nearly 4 ½ years of tamoxifen. She recently stopped the tamoxifen on her own (We were planning to give her five years of tamoxifen) because she was having some side effects from that drug.

She is feeling great. Her bilateral mastectomy scars are clean. No lymphedema of the arm. Lymph node survey is negative.

History vs. Active Cancer

She is taking calcium with vitamin D 1,800 mg a day. She says she is exercising regularly. She had a bone density done about a year and a half ago which showed a T score in her spine of -1.3, left femoral neck -1.1 and left hip was -1.3, showing some osteopenia in all sites. I will order her another DEXA scan to be done in the next few days.

Provider Y, MD

Accurate Clinical Picture

- Document diagnoses that affect care
  - How is the care affected?
  - What was your evaluation?
  - Did you make any changes or alter treatment based on an existing diagnosis?

Example

HPI:
CKD (chronic kidney disease). Reported by patient. Quality: Evaluated Creatine; glomerular filtration rate (GFR).
Context: diabetic duration; diabetic neuropathy; history of diabetes.

COPD. Reported by patient. Onset/Timing: chronic; chronic: has not changed. Duration: has noted for years.
Severity: mild. Quality: symptoms worse during the day. Alleviating Factors: relieved with rest; relieved with bronchodilator. Aggravating Factors: worse with exertion. Associated Symptoms: no snoring; no excessive daytime sleepiness; no arousals from sleep; no dyspnea; no decrease in exercise capacity; no fatigue; not coughing up sputum; no fever; no weight loss; no depression; cough; wheezing.

Diabetes. Reported by patient. Duration: chronic. Control: improved since last visit; usually poorly controlled. Compliance: compliant with medications; compliant with follow-up visits; noncompliant with diet; noncompliant with home glucose monitoring. Self Care: monitoring glucose; seeing eye doctor regularly; checking feet regularly. Associated Symptoms: no weight gain; no weight loss; no dizziness; no sweats; no headaches; no confusion; no increased thirst; no increased appetite; no increased urination; no blurred vision; no numbness of feet; no calluses on feet; no kidney disease. Complications: no diabetic retinopathy; no diabetic neuropathy; no peripheral vascular disease; no hypertension; no coronary artery disease; no diabetic ketoacidosis; diabetic nephropathy; hyperlipidemia.

Hypothyroidism. Reported by patient. Quality: not changing. Onset/Timing: better. Context/ Risk: normal thyroid levels; no history of head or neck radiation during childhood; no history of thyroid disease; no history of hyperthyroidism; no excess iron exposure; history of hypothyroidism. Modifying Factors: nothing makes it worse; medication. Associated Symptoms: no cold intolerance; no heat intolerance; no weight loss; no weight gain; no double vision; no dry eyes; no hoarseness; no difficulty swallowing; no neck masses; no deepening of the voice; no fast heart rate; no increased blood pressure no palpitations, no chest pain, no chest tightness or pressure; no constipation; no diarrhea; no vomiting; no decreased appetite; no loose stools; no excessive sweating; no joint pain; no numbness; no tingling of the hands or feet; no dry skin; no tremor; no nervousness; no anxiety; no depression; no fatigue; no sleep difficulties; no skin changes; no hair changes.

Problems:
Hypothyroid
Hyperlipidemia
Allergies: Reviewed Allergies: NKDA

Example

Medications: Reviewed
Medications:
ASA-ACETAMINOPHEN-CAFF-BUFFERS

COMBIVENT RESPIMAT 20 MCG
ACTUATION AEROSOL INHALER
DONEPEZIL 10 MG TAB
DOXAZOSIN 1 MG TAB
GLIPIZIDE ER 10, EXTENDED RELEASE
LISINOPRIL 10 MG TAB
LUTEIN – ZEAXANTHIN
METFORMIN 500 MG TAB
SYNTHYROID 50 MCG TAB
VITAMIN E
ZOCOR 20 MG TAB

Vaccines: Reviewed Vaccines:
Influenza, seasonal, injectable 20XX

Social History: Family Practice: Alcohol Intake: none. Caffeine Intake: moderate. Illicit Drugs: none. Marital Status: single. Non-smoker. Smoking status: former smoker.
Reviewed Past Medical History: COPD: Y. Headaches or Migraines: Y.
Family History: Mother – hypertension.

Surgical History:
Cholecystectomy – 20XX
Appendectomy – 20XX

Example

Vitals: Height: 5’7”, Weight: 169 lbs 2 oz, BMI: 26.5, BP: 116/64 sitting R arm, Pulse: 92 bpm regular, RR: 18, O2Sat: 94% Room Air, Temp: 98.2° oral

Physical Exam: Patient is an 80-year-old male.

Constitutional: General Appearance: healthy-appearing, well-nourished, and well-developed. Level of Distress: NAD. Ambulation: ambulating normally.

Psychiatric: Insight: good judgement. Mental Status: normal mood and affect and active and alert. Orientation: to time, place, and person. Memory: recent memory normal and remote memory normal.

Head: normocephalic and atraumatic

Neck: supple, FROM, trachea midline, and no masses. Lymph Nodes: no cervical LAD, supraclavicular LAD, axillary LAD, or inguinal LAD. Thyroid: no enlargement or nodules and non-tender.

Lungs: Respiratory Effort: no dyspnea. Percussion: no dullness, flatness, or hyperresonance. Auscultation: no rales/crackles or rhonchi and decreased breath sounds, diminished air movement, and expiratory wheezing.

Cardiovascular: Apical Impulse: not displaced. Heart Auscultation: normal S1 and S2; no murmurs, rubs, or gallops; and RRR. Neck Vessels: no JVD, carotid bruits, or hepatojugular reflux. Pulses Including Femoral/Pedal: normal throughout.

Abdomen: Bowel Sounds: normal. Inspection and Palpation: no tenderness, guarding, masses, rebound, tenderness, or CVA tenderness and soft and non-distended. Liver: non-tender and no hepatomegaly. Spleen: non-tender and no splenomegaly. Hernia: non palpable.

Skin: Inspection and Palpation: no rash, lesions, induration, nodules, jaundice, or abnormal nevi and good turgor. Nails: normal.

Assessment/Plan:

UNSPECIFIED HYPOTHYROIDISM E03.9

DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION, TYPE II OR UNSPECIFIED TYPE E11.9

MIXED HYPERLIPIDEMIA E78.2

DEMENTIA F03.9

ESSENTIAL HYPERTENSION I10

Questions?