



HEALTHCON



The EHR says it's a 99215

Angela Jordan, CPC, COBGC, AAPC Fellow
Senior Managing Consultant



AAPC National Advisory Board, Southwest
AAPCCA BOD Chair 2012 - 2013

Leveling E/M services in an EHR can be perilous. We will explore the parts of the electronic health record that are off limits, and areas that are questionable for compliance when determining the E/M level for an encounter. We will apply CMS guidance to ROS, PFSH, and template information in the EHR to E/M coding, with case studies from EHRs.

Disclaimer

The following program is founded upon the principles of coding, documentation and regulatory compliance as interpreted by the presenter. Even though the presenter has made every effort to produce reliable content, attendees are encouraged to verify the information prior to implementing changes within their practice. The presenter has no conflicts of interest to report at this time.

OIG Report - OEI-01-11-00570

Electronic health records (EHRs) replace traditional paper medical records with computerized recordkeeping to document and store patient health information. Experts in health information technology caution that EHR technology can make it easier to commit fraud. The Office of the National Coordinator for Health Information Technology (ONC), which coordinates the adoption, implementation, and exchange of EHRs, contracted with RTI International (RTI) to develop recommendations to enhance data protection; increase data validity, accuracy, and integrity; and strengthen fraud protection in EHR technology. This study determined how hospitals that received EHR Medicare incentive payments, administered by the Centers for Medicare & Medicaid Services (CMS), had implemented recommended fraud safeguards for EHR technology.

What the OIG Found

Nearly all hospitals with EHR technology had RTI-recommended audit functions in place, but they may not be using them to their full extent. In addition, all hospitals employed a variety of RTI-recommended user authorization and access controls. Nearly all hospitals were using RTI-recommended data transfer safeguards. Almost half of hospitals had begun implementing RTI-recommended tools to include patient involvement in anti-fraud efforts. Finally, only about one quarter of hospitals had policies regarding the use of the copy-paste feature in EHR technology, which, if used improperly, could pose a fraud vulnerability.

Paper to EHR

- Documentation rules have not changed
- E/M leveling tools are just tools
- EHR's have created new concerns

Noridian - EMR

Noridian Part B MR has noted that some Electronic Medical Record (EMR) software programs auto-populate certain aspects of the medical record with information that is not patient specific. This issue is more profound in the HPI when discussing the context of a certain illness and/or co-morbidity. Documentation to support services rendered needs to be patient specific and date of service specific. These auto-populated paragraphs provide useful information such as the etiology, standards of practice, and general goals of a particular diagnosis. However, they are generalizations and do not support medically necessary information that correlates to the management of the particular patient. Part B MR is seeing the same auto-populated paragraphs in the HPI's of different patients. ***Credit cannot be granted for information that is not patient specific and date of service specific.***

NGS - HPI

Is it necessary that the HPI only be documented by the performing provider?

Answer: There are two elements of history that can be elicited and documented by someone other than the provider: the ROS and the PFSH. A staff member or medical student may elicit this information from the patient, but the provider is obliged to review it, amend it if necessary, and indicate in writing or electronically that he/she has done so. The provider is responsible for eliciting and documenting the HPI, since this requires defined clinical skill. It is, however, permissible for the provider to utilize the services of a Scribe in documenting the HPI, as with any other element of an E&M service.

Is it acceptable for ancillary staff to gather HPI information and enter into the EHR office note, so that the doctor can come along after to review and edit it, essentially making it his own?

Answer: Only the performing provider may elicit and document the HPI, since this requires defined clinical skill.

Noridian - HPI

Q33. If someone other than a physician collects the history of present illness (HPI), documents it and then the physician reiterates the HPI with the patient, can the physician refer to the other person's documentation with the notation, "I re-obtained the HPI, reviewed the documentation and agree?"

A33. The HPI must be done and individually documented by the physician.

Noridian - HPI

Q34. An RN or NP obtained the HPI and documents it. The physician then goes over the information with the patient to verify it, can the MD say, "I verified the HPI with the patient. Please see RN/NP documentation above?"

A34. If that scenario takes place, the information will not be accepted if reviewed. The MD must gather and document the HPI themselves. The ROS and PFSH can be recorded by other staff and the physician then reviews and confirms the information.

CGS - HPI

- The HPI is the “physician work” associated with the medical clinical judgment in gathering the appropriate information in relation to a chief complaint.
- Reviewing information obtained by ancillary employees and writing a declarative sentence does not suffice for the history of present illness (HPI) representing “physician work”.
 - In some instances an ER triage nurse or office nurse asks a patient some of the HPI questions and records this information. **This should be treated only as preliminary information.**
 - The physician must review this preliminary information with the patient and further delve into the responses provided by a patient by obtaining additional clinical information as a physician or qualified NPP is educated to do and to discern how to proceed with the exam and medical decision making

Palmetto GBA - HPI

Ancillary staff may only document:

- Review of systems (ROS)
- Past, family and social history (PFSH)
- Vital signs

These three areas must be reviewed by the physician or non-physician practitioner (NPP) who must write a statement that it is reviewed and correct or add to it.

Only the physician or NPP that is conducting the E/M service can perform the history of present illness (HPI). This is considered physician work and not relegated to ancillary staff. The exam and medical decision making are also considered physician work and not relegated to ancillary staff. In certain instances, an office or emergency room triage nurse may document pertinent information regarding the chief complaint (CC)/HPI, but this information should be treated as preliminary information. The physician providing this E/M service must consider this information preliminary and needs to document that he or she explored the HPI in more detail.

WPS GHA - HPI

Who can perform the History of Present Illness (HPI) portion of the patient's history?

Answer:

The history portion refers to the subjective information obtained by the physician or ancillary staff. Although ancillary staff can perform the other parts of the history, that staff cannot perform the HPI. Only the physician or non-physician practitioner can perform the HPI.

Reviewed on Jun 8, 2016

WPS GHA - HPI

If the nurse takes the HPI, can the physician then state, "HPI as above by the nurse" or just "HPI as above in the documentation"?

Answer:

No. The physician billing the service must document the HPI.

Reviewed on Jun 8, 2016

WPS GHA – Double Dipping

Can a physician count a single history item in both the HPI and ROS?
For example, could we count "shortness of breath" as an associated sign and symptom in the HPI and respiratory system in the ROS?

Answer:

A clearly documented medical record would prevent the need to "double-dip" for HPI and ROS, but WPS Medicare, in rare circumstances, could accept counting one statement in both areas if appropriate.

Reviewed on Jun 8, 2016

Palmetto GBA – Double Dipping

E/M Weekly Tip: Double Dipping

Documentation cannot be used twice under the History Component. This is referred to as 'double dipping.' Example: Allergies may be used under the ROS (Allergic/Immunologic) or under past history.

Last Updated: 07/18/2016

Noridian - Cloning

Q30. What does Noridian consider to be a cloned E/M note? If a note is very similar from day to day but is accurate to what happened, is this a cloned note?

A30. In general, if only the DOS and vital signs are different, then Noridian would most likely consider it cloned. We do realize that there may not be changes day to day detail the stability of the patient but it is important to include the details in the documentation. Medical necessity is also important here. To repeat a family and social history on visits every week or two would be considered cloning or at least not reasonable and necessary.

Noridian – Complete Medical Record

- Physician orders and/or certifications of medical necessity
- Patient questionnaires associated with physician services
- Progress notes of another provider that are referenced in your own note
- Treatment logs
- Related professional consultation reports
- Procedure, lab, x-ray and diagnostic reports
- Billing provider notes for billed date of service

Noridian - Falsified Documentation

Providers are reminded that deliberate falsification of medical records is a felony offense and is viewed seriously when encountered. Examples of falsifying records include:

- Creation of new records when records are requested
- Back-dating entries
- Post-dating entries
- Pre-dating entries
- Writing over, or
- Adding to existing documentation (except as described in late entries, addendums and corrections)

Noridian – Amended Records

- Correction of electronic records should follow the same principles of tracking both the original entry and the correction with the current date, time, reason for the change and initials of person making the correction. When a hard copy is generated from an electronic record, both records must show the correction. Any corrected record submitted must make clear the specific change made, the date of the change, and the identity of the person making that entry.

CGS – Amended Records

Medical record keeping within an EHR deserves special considerations; however, the principles *specified above* remain fundamental and necessary for document submission to MACs, CERT, Recovery Auditors, and ZPICs.

Records sourced from electronic systems containing amendments, corrections or delayed entries must:

- Distinctly identify any amendment, correction or delayed entry, and
- Provide a reliable means to clearly identify the original content, the modified content, and the date and authorship of each modification of the record.

CGS - Exam

1995 Examination – What does “more detail” mean, when it comes to a “detailed” exam?

- “More detail” consists of at least 2 findings for at least 2 “body areas” or “organ system's
- Example: Abdomen: soft, non-tender, BSx4, and Respiratory: Lungs CTA, No wheezing or rhonchi

Noridian – Electronic Signatures

- Chart 'Accepted By' with provider's name
- 'Electronically signed by' with provider's name
- 'Verified by' with provider's name
- 'Reviewed by' with provider's name
- 'Released by' with provider's name
- 'Signed by' with provider's name
- 'Signed before import by' with provider's name
- 'Signed: John Smith, M.D.' with provider's name
- Digitalized signature: Handwritten and scanned into the computer
- 'This is an electronically verified report by John Smith, M.D.'
- 'Authenticated by John Smith, M.D.'

Note: 'Signed but not read' is not acceptable

Noridian - Order Authentication

As a condition of participation, 42 CFR 428.24(c)(2) This link takes you to an external website. states “All orders, including verbal orders, must be dated, timed, and authenticated promptly by the ordering practitioner or by another practitioner who is responsible for the care of the patient only if such a practitioner is acting in accordance with State law, including scope-of-practice laws, hospital policies, and medical staff bylaws, rules, and regulations.”

NGS - Cloning

Documentation is considered cloned when it is worded exactly like or similar to previous entries. It can also occur when the documentation is exactly the same from patient to patient. Individualized patient notes for each patient encounter are required. . . .

Whether the documentation was the result of an Electronic Health Record, or the use of a pre-printed template, or handwritten documentation, cloned documentation will be considered misrepresentation of the medical necessity requirement for coverage of services due to the lack of specific individual information for each unique patient. Identification of this type of documentation will lead to denial of services for lack of medical necessity and the recoupment of all overpayments made.

CGS - Cloning

Cloning occurs when medical documentation is exactly the same from beneficiary to beneficiary. It would not be expected that every patient had the exact same problem, symptoms, and required the exact same treatment. This "cloned documentation" does not meet medical necessity requirements for coverage of services rendered due to the lack of specific, individual information.

All documentation in the medical record must be specific to the patient and her/his situation at the time of the encounter. Cloning of documentation is considered a misrepresentation of the medical necessity requirement for coverage of services. Identification of this type of documentation will lead to denial of services for lack of medical necessity and recoupment of all overpayments made.

Palmetto GBA - Cloning

The word 'cloning' refers to documentation that is worded exactly like previous entries. This may also be referred to as 'cut and paste', copy and paste, or 'carried forward.' Cloned documentation may be handwritten, but generally occurs when using a preprinted template or an Electronic Health Record (EHR).

EHRs replace traditional paper medical records with computerized recordkeeping to document and store patient health information. EHRs may include patient demographics, progress notes, medications, medical history, and clinical test results from any health care encounter.

While these methods of documenting are acceptable, it would not be expected the same patient had the same exact problem, symptoms, and required the exact same treatment or the same patient had the same problem/situation on every encounter. Authorship and documentation in an EHR must be authentic.

Cloned documentation does not meet medical necessity requirements for coverage of services.

Identification of this type of documentation will lead to denial of services for lack of medical necessity and recoupment of all overpayments made.

Over-documentation is the practice of inserting false or irrelevant documentation to create the appearance of support for billing higher level services. Some EHR technologies auto-populate fields when using templates built into the system. Other systems generate extensive documentation on the basis of a single click of a checkbox, which if not appropriately edited by the provider may be inaccurate. Such features produce information suggesting the practitioner performed more comprehensive services than were actually rendered.

Last Updated: 02/28/2017

Palmetto GBA – Cloning

E/M Weekly Tip: Cloning (Chief Complaint (CC), History of Present Illness (HPI), Review of Systems (ROS) and Examination)

Always document the Chief Complaint (CC) and History of Present Illness (HPI) based on the patient's description on that day. Never copy it from a previous visit. Only use the Review of Systems (ROS) and examination that is relevant to that day's visit.

Last Updated: 01/09/2017

ZPIC - Overpayment

IV. Additional Findings

This section explains any investigative actions and findings during which the medical review was taking place. Additionally, this section outlines the decision and basis for the extrapolation of the selected sample.

Observation / Trends

Documentation was **identical or nearly identical** to documentation for a different date of service for the same beneficiary. CCN: XXXXxxxxx (3 dates of service for this claim); CCN: XXXXXXxxxxxxxxx (3 dates of service for this review).

CGS – Signature Update

There are no regulatory timeliness guidelines over and above the IOM reference cited above. However, reason would dictate that 10 working days should be ample time to finalize a visit note and sign/authenticate it. If there is a delay past this reasonable timeframe, an attestation should be submitted with appropriate documentation.

[IOM 100-08 Medicare Program Integrity Manual, Chapter 3 Verifying Potential Errors and Taking Corrective Actions, section 3.3.2.4 Signature Requirements](#)

Novitas – Electronic Signatures

- “Electronically signed by” with provider’s name
- “Verified by” with provider’s name
- “Reviewed by” with provider’s name
- “Signed by” with provider’s name
- “Signed: John Smith, M.D.” with provider’s name
- This is an electronically verified report by John Smith, M.D.
- Authenticated by John Smith, M.D
- Authorized by: John Smith, M.D
- Confirmed by with provider’s name
- Electronically approved by with provider’s name
- Novitas expects the phrase/signature to be dated.

Palmetto GBA – Electronic Signatures

Electronic:

- Electronic signatures usually contain date and timestamps and include printed statements (e.g., 'electronically signed by' or 'verified/reviewed by') followed by the practitioner's name and preferably a professional designation. Note that the responsibility and authorship related to the signature should be clearly defined in the record.
- Digital signatures are an electronic method of a written signature that is typically generated by special encrypted software that allows for sole usage

Note: Be aware that electronic and digital signatures are not the same as 'auto-authentication' or 'auto-signature' systems, some of which do not mandate or permit the provider to review an entry before signing. Indications that a document has been 'Signed but not read' are not acceptable.

WPS GHA - Disclaimers

WPS GHA Medicare has recently been informed of a new trend in medical record documentation - that of using some type of disclaimer. Examples include the following: "Due to possible errors in transcription, there may be errors in documentation"; "Due to voice recognition software, sound alike and misspelled words may be contained in the documentation"; and "I am not responsible for errors due to transcription." Providers are responsible for the medical record documentation. Disclaimers such as those above do not remove that responsibility. The provider should verify the information is complete and accurate prior to attaching his/her signature.

More [Guidance for Provider Signature Requirements](#) can be found on our website.

WPS GHA – EMR Documentation

This question pertains to an Electronic Medical Record (EMR.) We have always been taught that the progress note "stands alone." When we are auditing physician's notes to determine if they are billing the appropriate level of service, what parts of the EMR can be used toward their levels without requiring them to reference it? We are referring specially to Growth charts, Past, Family, & Social History, Medication Listings, Allergies, etc.

Answer:

If the physician were not referencing previous material in the EMR, then the information would not be used in choosing the level of E/M service. The physician would document any previous information he/she reviewed for today's encounter.

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WPS GHA – Non-Patient Specific Information

There appears to be a heightened interest among medical providers to include non-patient specific information in medical record documentation. An example is, "if the patient was a smoker, they were advised to stop," or "education was given, if new medications were prescribed." Providers need to be cognizant that the medical record must demonstrate the existence of a relationship between the patient and the provider and that it is difficult and potentially dangerous to design a medical treatment plan in which "one size fits all."

Documentation must support that only medically necessary services were actually provided in order for Medicare to consider reimbursement for otherwise covered services.

Palmetto GBA - Time

E/M Weekly Tip: Counseling/Coordination Documentation Requirements

Documentation must include the following:

- Duration of counseling/coordination of care (the duration may be documented as total time or a statement that identifies that **more than half the time** was counseling/coordination of care e.g. greater than 50% was spent on counseling/coordination of care)
- Duration of the visit (may be total time or time in/out)
- Sufficient documentation to support counseling/coordination of care

History of Present Illness

Amenorrhea

Add New Sentence

Add Sentence From Library

Add Paragraph Break

Add New Line

Duplicate Sentence

Delete

Default Mode: Paragraph Form

IS THIS THE PRIMARY COMPLAINT?

▶ IS THIS THE PRIMARY COMPLAINT? --> The patient is a

AGE/RACE/ETHNICITY/SEX , GRAVIDA PARA , who presents with IS SHE HAVING MENSES? .

▶ IS SHE HAVING MENSES? --> light menses

Her last period occurred on LMP and lasted HOW LONG DID THE PERIOD LAST? . She currently has periods approximately every HOW FREQUENT ARE HER PERIODS? .

▶ IS SHE HAVING MENSES? --> light menses

She currently has periods approximately every HOW FREQUENT ARE HER PERIODS? .

▶ IS THIS THE PRIMARY COMPLAINT? --> The patient also complains of

ARE THERE OTHER SYMPTOM COMPLAINTS? .

▶ ARE THERE OTHER SYMPTOM COMPLAINTS? --> light menses

Her last period occurred on LMP and lasted HOW LONG DID THE PERIOD LAST? . She currently has periods every HOW FREQUENT ARE HER PERIODS? .

▶ IS SHE HAVING MENSES? --> no menses

Her last period occurred WHEN DID THE LAST PERIOD OCCUR?

▶ WHEN DID THE LAST PERIOD OCCUR? --> (per the PSFH) on

LMP

▶ WHEN DID THE LAST PERIOD OCCUR? --> on

ON WHICH DATE WAS THE LMP?

▶ WHEN DID THE LAST PERIOD OCCUR? --> approximately

HOW LONG AGO WAS THE LAST PERIOD? ago,

▶ IS SHE HAVING MENSES? --> no menses

Prior to this period, her cycles were WHAT IS THE REGULARITY OF HER MENSES? , occurring approximately every HOW FREQUENT ARE HER PERIODS? .

E&M (0)

E&M (2)

E&M (3)

E&M (1)

E&M (1)

E&M (2)

E&M (0)

E&M (0)

E&M (0)

E&M (0)

E&M (0)

Review of Systems:

General: POSITIVE: malaise/fatigue; negative: chills, fever

Skin: negative: rash

Eye: negative: photophobia, vision changes

Ear: negative: hearing loss

Nose: negative: congestion, nose bleeds

Mouth/Throat: negative: dysphagia, throat pain

Respiratory: negative: cough, dyspnea

Cardiovascular: negative: chest pain, lower extremity swelling, orthopnea

Gastrointestinal: POSITIVE: abdominal pain, nausea, vomiting; negative: constipation, diarrhea

Gastrorectal: negative: change in bowel habits, hematochezia, melena

Genitourinary: negative: dysuria, hematuria, urinary frequency

Neuro: POSITIVE: weakness; negative: confusion/memory loss, headache

5. **PE Calculator** in the E&M section--Regardless of the medical specialty, the calculator will default the PE type to GMS (General Multi-Systems) when another of the PE types are equal to the number of bullets compared to the GMS exam.

- **Comprehensive PE** > GMS exam--Minimum of 9 subsystems with 2 bullets each. > Specialty exam--ALL bullets in the shaded box, at least one in the unshaded boxes.
- **Detailed PE** > Two bullets in each of 6 subsystems or total of 12 bullets in 2 subsystems (**2 of 6** or **12 of 2** bullets).
- **Expanded Problem Focused PE** > At least 6 bullets in one or more.
- **Problem Focused PE** > 1-5 bullets in one or more.

Note: The user has the ability to add more sub-systems and sub-bullets, as well as moving sub-systems and sub-bullets around in the tree; however, they cannot map these to the E&M calculator, they get no credit for these new sections.

Vital Signs:

Time	Ht Ft	Ht In	Wt Lb	BMI	BP	BP Position	Pulse	Temp F	Resp	Pulse Ox
2:03 PM	4.0	11.25	184.00	36.85	120/80	sitting	80	97.6		

Physical Exam

System	Findings	Details
Constitutional	Neg	Level of distress - Normal. Nourishment - Normal. Overall appearance - Normal.
Neck Exam	Neg	Palpation - Normal. Thyroid gland - Normal.
Respiratory	Neg	Inspection - Normal. Auscultation - Normal. Effort - Normal.
Musculoskeletal	Pos	Lumbar spine - muscle spasm, Range of motion: moderate pain w/motion.
Musculoskeletal	Neg	Gait - Normal. Cervical spine - Normal. Thoracic spine - Normal.
Neurological	Neg	Memory - Normal. Cranial nerves - Cranial nerves II through XII grossly intact.
Psychiatric	Neg	Orientation - Oriented to time, place, person & situation. Appropriate mood and affect. Normal insight. Normal judgment.
Cardiovascular	Neg	Regular rate and rhythm. No murmurs, gallops, or rubs.

Examination Level Summary:

Calculated exam level: **4**
Comprehensive

Mult system 95 physical exam totals:

Systems documented: **6**
Detailed systems: **4**
Body areas: **2**
Complete systems: **1**

95 Physical Exam:**Body Areas:**

Head (including face):	0	Back (including spine):	2
Neck:	3	Left lower extremity:	0
Chest (including breast/axillae):	0	Right lower extremity:	0
Abdomen:	0	Left upper extremity:	0
Genitalia/groin/buttocks:	0	Right upper extremity:	0

Organ Systems:

Constitutional:	8	Genitourinary:	1
Eyes:	0	Musculoskeletal:	2
ENMT:	0	OMM Regions:	0
Cardiovascular:	0	Skin:	0
Respiratory:	3	Neurologic:	2
Gastrointestinal:	0	Psychiatric:	4
		Heme/lymph/imm:	0

**HEALTHCON**

The patient is a 67 year old female, presenting for a new patient visit with the following condition(s):

PRESENTING PROBLEM: Smashed left hand on a piece of steel.

Bucket of a tractor was lowered onto left hand obvious swelling and some discoloration. Pt has some difficulty with ROM of index finger.

EARS : Patient ears were examined for pain, tenderness, or swelling of external ear, cartilage and pinna. Gross hearing was determined at conversational level. External ear canal was examined for presence or absence of cerumen impaction (for which the right EAC was positive for cerumen), redness, discharge, debris or signs of otitis externa. Tympanic membrane examined for light reflex, and abnormal signs or TM redness, bulging or fluid behind TM, or perforation. No significant abnormal findings noted.

THROAT/TEETH/MOUTH/SINUS: Patient examined for gross facial swelling, tenderness of frontal or maxillary sinuses (positive). Examined for stridor or drooling and ability to handle secretions. Lips and gingiva examined for hydration or lesions. Dentition noted in exam. The presence or absence of tonsils was examined for swelling, redness(mild positive), or presence of pus. Posterior pharynx examined for redness, pebbling, swelling or discharge. No significant abnormal findings noted.

GU Female: Pelvic exam reveals external genitals normal, urethra normal, bladder not distended, cervix nulliparous without discharge, uterus not enlarged, no cervical motion tenderness, and adnexae normal.

Eccymosis and edema noted to dorsal aspect of left hand 2/2 crush type injury. Decreased ROM to index finger and diminished grip strength. No neurovascular compromise noted.

#	Diagnosis Description	Code	Status
1	Pain of left calf	M79.662	

Evaluation and Management Coding

Medical Decision Making [View MDM Guidelines](#) | [View Risk Table](#)

- ☒ Straight forward
 ☒ Low complexity
 ☐ Moderate complexity
 ☐ High complexity

Counseling

- ☐ Counseled greater than 50% of time and documented content

Total visit time (minutes):

◆ [Counseling Details](#)

Total counsel time (minutes):

Evaluation and Management Code

Visit code:

Modifier(s):

[Calculate Code](#)

Submitted

[CQM Check](#)

Calculated EM code:

Submitted code:

Submitted eRx code:

◆ [Additional E&M Code](#) | ◆ [View Other Codes](#) | ◆ [SNOMED Visit Type \(optional\)](#) | ◆ [Medicare Preventive Codes](#)

New patient:

- ☐ 99201
☐ 99202
☐ 99203
☐ 99204
☐ 99205

Established:

- ☐ 99211
☐ 99212
☒ 99213
☐ 99214
☐ 99215

Consultation:

- ☐ 99241
☐ 99242
☐ 99243
☐ 99244
☐ 99245

Preventive new:

- ☐ 99381
☐ 99382
☐ 99383
☐ 99384
☐ 99385
☐ 99386
☐ 99387

Preventive established:

- ☐ 99391
☐ 99392
☐ 99393
☐ 99394
☐ 99395
☐ 99396

Preventive counseling:

- ☐ 99401
☐ 99402
☐ 99403
☐ 99404

Post Op:

- ☐ 99024

Prenatal:

- ☐ 59425

Visits greater than 6:

- ☐ 59426

Behavioral Health
Pain of left calf (M79.662).

Further diagnostic evaluations ordered today include(s) LE VENOUS, UNILATERAL Left calf to be performed on 02/01/2016. Today's instructions / counseling include(s) if negative, heat, ice, Baclofen can take BID for couple days, call if worsen and pending ultrasound rule out DVT. She is to schedule a follow-up visit As Needed.

E&M Level Summary

Calculated history level:

Comprehensive

History of present illness:

HPI:

5

Past medical, family, social history:

3

Review of systems:

13

Calculated exam level:

Detailed

Mult system 95 physical exam totals:

Systems documented:

4

Detailed systems:

3

Body areas:

1

Complete systems:

0

Office Services:

Status	Order	Reason	Interpretation	Value	Units
completed	CXR - 2V	Respiratory Insufficiency	Sent-Out	Nothing acute.	1
completed	EKG	Respiratory Insufficiency	normal		1

HPI: Patient is here for an acute visit for hypertension. She has the following cardiac diagnoses:

1. Hypertension
2. Shortness of breath chronically
3. Bradycardia secondary to calcium channel blocker therapy now resolved.
4. Diastolic Dysfunction Grade II
5. Intolerance to norvasc which was back pain.

She has had good blood pressures at Rockwell. She has it checked by one of the nurses there and it has been within normal limits with Systolic blood pressures in the 120's to 130's. She states she has been under a lot of stress today. One of her coworkers was found dead and she just heard about it earlier today. She said she has been upset over it. She has a sleep study scheduled through Dr. office on May 15.

Physical Exam **(No changes noted in this exam, and no notation that no changes from previous exam date is documented)**

PHYSICAL EXAMINATION:

NECK: Supple. Trachea midline. No jugular venous distention noted. Good carotid upstroke. No bruits. No thyromegaly or lymphadenopathy is noted.

LUNGS: Clear without any rales, rhonchi or wheezes. Good chest expansion bilaterally.

HEART: Tones are regular without any murmurs, rubs, gallops, lifts or heaves. PMI is unremarkable. No subclavian or abdominal bruits are noted. There are good distal pulses.

PLANS:

1. Hypertension is uncontrolled **today. She is under a lot of stress today. She will continue to get her blood pressure checked at work once or twice a week. She states that the blood pressure has been under excellent control at work with SBP of 120's to 130's. She is currently on coreg, hydralazine, hctz, and lisinopril. Her renal artery ultrasound was negative for stenosis. She has a sleep study that has been ordered by Dr. Cearras' office for May 15.** She had a normal nuclear stress test 11/2014.
2. Shortness of breath chronically. This is chronic and controlled. Slightly improved on Advair.
3. Bradycardia secondary to calcium channel blocker therapy now resolved.
4. Grade II diastolic dysfunction. No signs of fluid overload.

Assessment and Plan:

Problem 1: Diabetes type I, Type 1 diabetes mellitus with chronic kidney disease, with long-term current use of insulin

Plan 1: Pt admitted after seizure episode. She was given a glucagon treatment and sugar was elevated upon arrival. BS rose to >400 and was placed on an insulin drip - sugars have improved.

feels up to eating solid food at lunch, no other tests scheduled. We'll transition to subcutaneous insulin at lunch. She uses a 1:20 carb ratio for insulin with meals we will use 3 units here.

Thank you - I will continue to monitor and maintain a blood glucose goal of 100-140 mg/dL

Assessment and Plan:

Problem 1: Diabetes type I, Type 1 diabetes mellitus with chronic kidney disease, with long-term current use of insulin

Plan 1: Pt admitted after seizure episode. She was given a glucagon treatment and sugar was elevated upon arrival. BS rose to >400 and was placed on an insulin drip - sugars improved and was transitioned to subcutaneous insulin yesterday. She had a low blood sugar of 36 at 1428 and an Ace team was called. She did eat a little at dinner and insulin was not given - consequently blood sugar rose to over 300 at bedtime. Blood sugar was 50 this morning after full dose of Lantus given. Adjustments have been made to insulin - discussed case with Dr. [REDACTED] today.

Physician Billing

Billing

Observation

- ☐ 99218 (Initial OBS 30 Minutes)
- ☐ 99219 (Initial Obs 50 Minutes)
- ☐ 99220 (Initial Obs 70 Minutes)
- ☐ 99224 (Subs Obs 15 Minutes)
- ☐ 99225 (Subs Obs 25 Minutes)
- ☐ 99226 (Subs Obs 35 Minutes)
- ☐ 99217 (DC Obs)
- ☐ 99234 (Obs/Inpt Care 40 Minutes)
- ☐ 99235 (Obs/Inpt Care 50 Minutes)
- ☐ 99236 (Obs/Inpt Care 55 Minutes)
- ☐ Time Spent (minutes):

Inpatient

- ☐ 99221 (Initial Inpt 30 Minutes)
- ☐ 99222 (Initial inpt 50 Minutes)
- ☐ 99223 (Initial Inpt 70 Minutes)
- ☐ 99231 (Subs Inpt 15 Minutes)
- ☐ 99232 (Subs Inpt 25 Minutes)
- ☐ 99233 (Subs Inpt 25 Minutes)
- ☐ 99238 (DC Inpt <30 Minutes)
- ☐ 99239 (DC Inpt >30 Minutes)
- ☐ 99234 (Obs/Inpt Care 40 Minutes)
- ☐ 99235 (Obs/Inpt Care 50 Minutes)
- ☐ 99236 (Obs/Inpt Care 55 Minutes)
- ☐ 99291 (Critical Care Eval/Mgt 30-74 Minutes) specify Minutes
- ☐ 99292 (Critical Care additional 30 min) specify Minutes

Initial Consults

- ☐ 99251 (Initial Inpt Consult 20 Minutes)
- ☐ 99252 (Initial Inpt Consult 40 Minutes)
- ☒ 99253 (Initial Inpt Consult 55 Minutes)
- ☐ 99254 (Initial Inpt Consult 80 Minutes)
- ☐ 99255 (Initial Inpt Consult 110 Minutes)
- ☐ Time Spent (minutes):

Post Surgical

- ☐ 99024 (Post Operative Visit)

Psychiatry

- ☐ 90792 (Diag Exam w/Med Services)
- ☐ 90832 (30 min w/Pt or Family)
- ☐ 99213 (Office or Other Outpt Vist)
- ☐ 99214 (Office or Other Outpt Vist/Established Pt)

Date	Description	Activity	Rslt	Desc
2/27/2015	Betadine Or PhisoHex	A4246	C	Completed
2/27/2015	Complex Laceration Head To 2.5 Cm	13131	C	Completed
2/27/2015	Sterile Water Saline 10ml	A4216	C	Completed
2/27/2015	Gauze Sterile Pad More Than 16sq In	A6220	C	Completed
2/27/2015	Irrigation Tray	A4320	C	Completed
2/27/2015	New Patient - Intermediate	99203	C	Completed

Laceration/avulsion was to left hand.

lateral edge Active bleeding to laceration site: positive.

Sensory deficit: negative

Peripheral Pulses/Circulation: normal

Size of Wound: 2 cm

Shape of wound: linear, jagged edges, small flap to base of wound but otherwise skin is avulsed. No closure of wound possible, see procedures.

Wound Contaminated: negative

Associated Injury: negative

Medical Procedures

We conducted a wound check and/or repair. Applicable diagnosis: 882.0-OPEN WOUND OF HAND. Prepared for the procedure by cleaning with hibicleanse. was 0 - 2.5 cm Instructions were provided to the patient as documented elsewhere. Patient's wound was cleansed post-operatively with saline. Patient tolerated the procedure well. A Gauze was used to cover the wound

Date	Description	Activity	Rslt	Desc
8/13/2015	Repair Superficial Wound(S)	12001	C	Completed
8/13/2015	Irrigation Tray	A4320	C	Completed
8/13/2015	Gauze Sterile Pad More Than 16sq In	A6220	C	Completed
8/13/2015	Surgical Trays	A4550	C	Completed
8/13/2015	New Patient - Intermediate	99203	C	Completed

Treatment / Orders / Work Restrictions

Ordered Tetanus/diphtheria/pertussis, acel (Tdap), 5 units-2 units-15.5 mcg/0.5 mL.1 injection I.M. Administer: 1 injection.

Prescribed Keflex 500 mg oral capsule, 500mg.1 capsule orally twice a day, for 5 days. Finish all medication. #10 capsules. No refills

Medical Procedures

We conducted a simple (0 - 2.5) laceration repair procedure on the finger. Applicable diagnosis: 883.0-OPEN WOUND OF FINGER. The laceration involved the following elements: epidermis. Prepared for the procedure by cleaning with betadine and saline irrigation. Wound was 1 cm. Wound was closed with dermabond. Instructions were provided to the patient as documented elsewhere. Patient tolerated the procedure well.

Patient Instructions

The laceration on your finger was closed with skin glue. The glue will stay on for approximately 3-5 days and then start to wear off. Apply a bandaid over the wound anytime you are around a dirty environment, avoid excessive water on your hands, and do not apply any ointments or creams to the wound. Clean with soap and leave dry most of the time. Take the antibiotics to avoid an infection. If you have concerns or feel it is infected then return and be seen again, otherwise no follow up is necessary.

HealthIT.gov

<http://dashboard.healthit.gov/index.php>



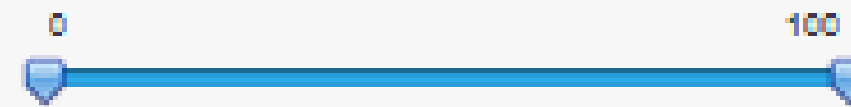
Choose a Measure Area

- ☒ EHR Adoption
- ☐ Health Information Exchange and Interoperability
- ☐ Patient Engagement

Choose an EHR Adoption Measure

% of all Physicians that have Adopted Certified EHRs

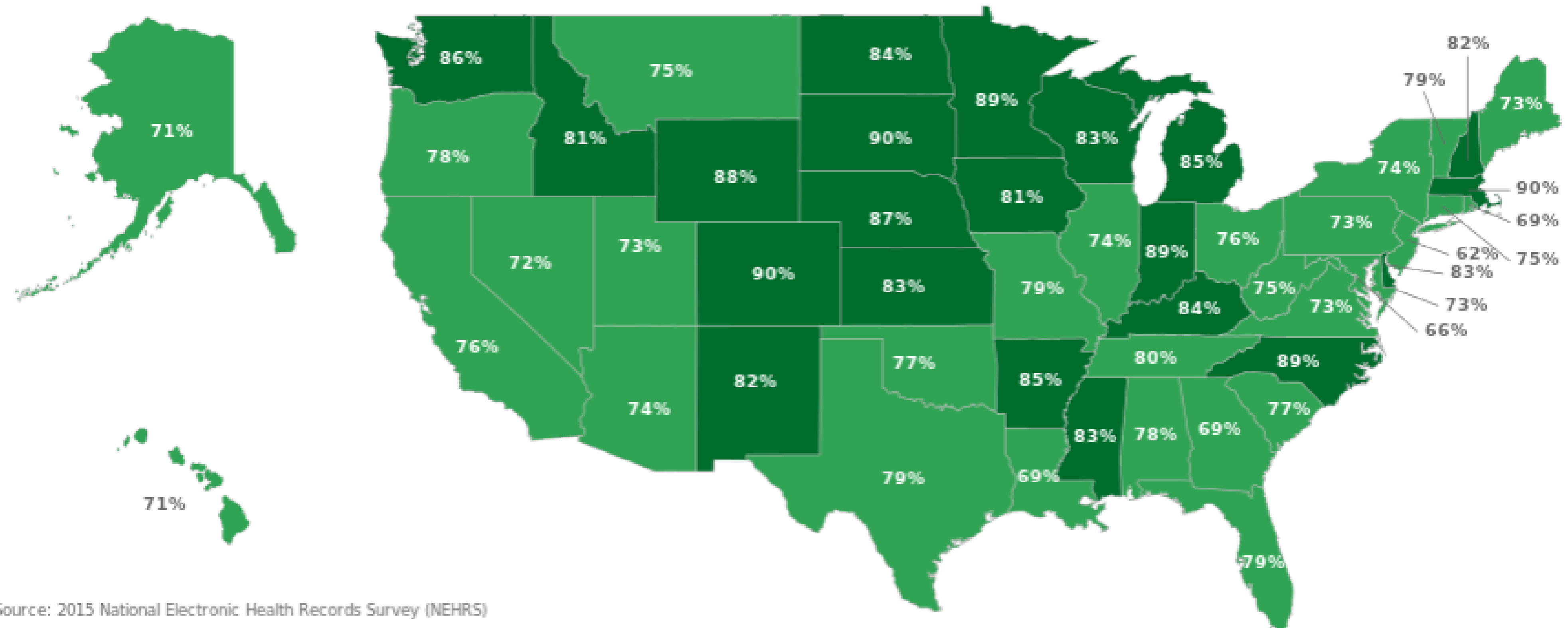
Choose a percentage range



☒ Click to display % labels

% of all Physicians that have Adopted Certified EHRs | National Avg = 78%

☐ 0 - 25 % ☐ 26 - 50 % ☐ 51 - 75 % ☐ 76 - 100 %



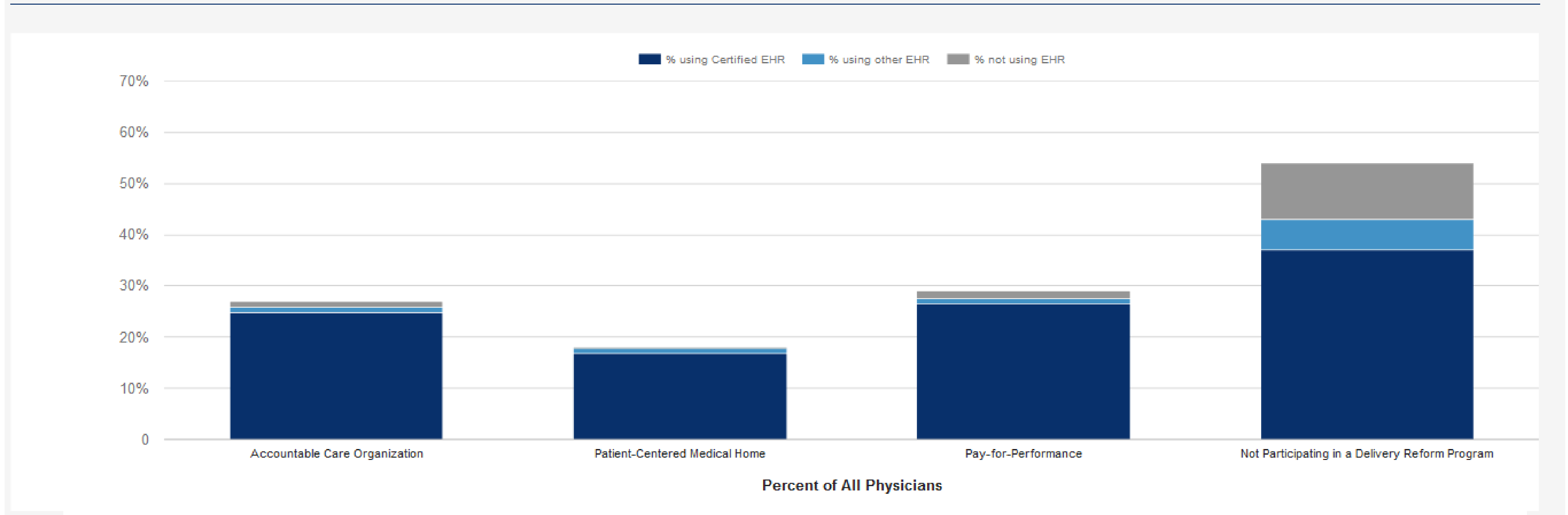
Source: 2015 National Electronic Health Records Survey (NEHR5)

ON

Electronic Health Record Use among Physicians Participating in Delivery Reform Programs

46% of physicians participate in delivery reform programs, and 90% of those physicians use a certified EHR

2015

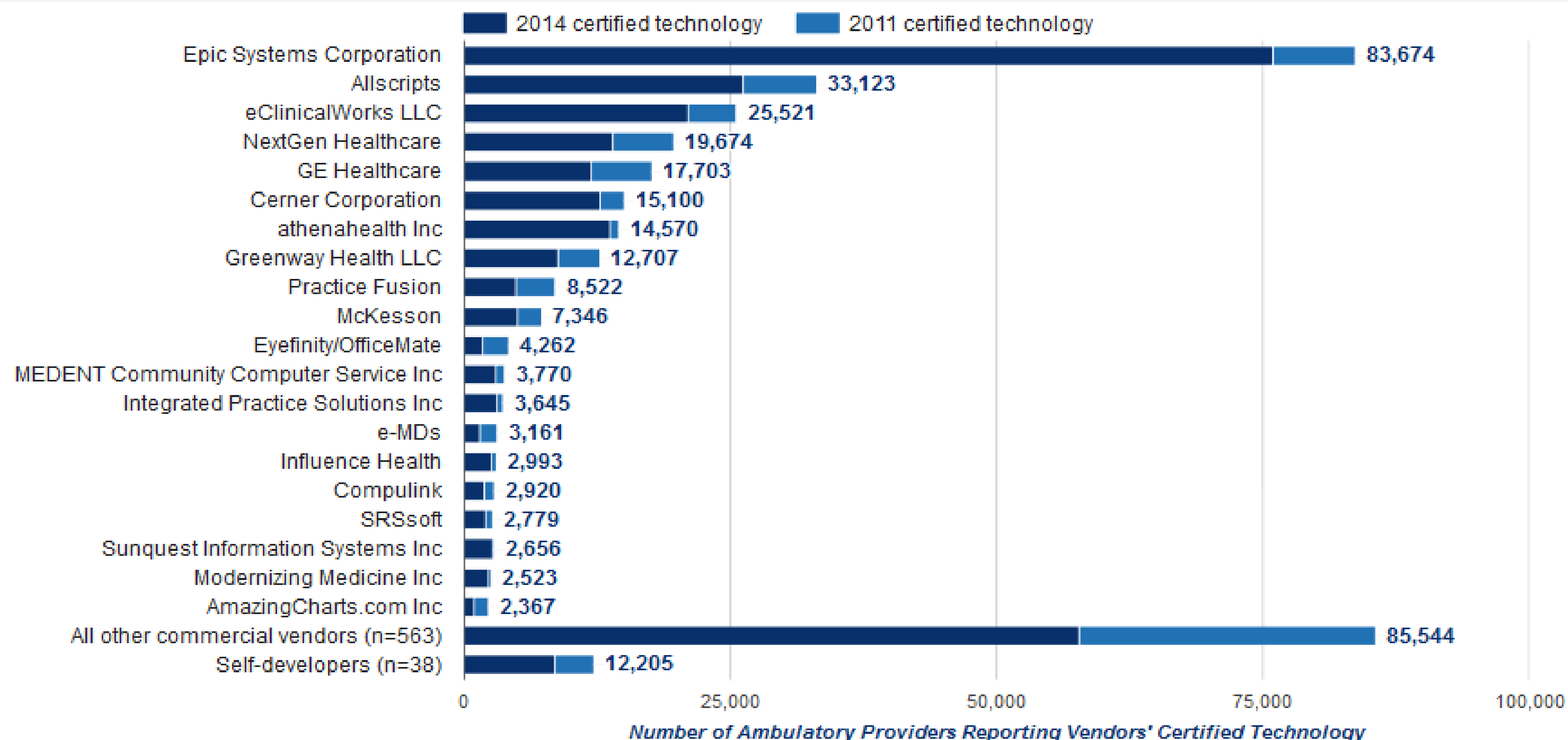


In 2015, [78% of all office-based physicians](#) reported use of a certified EHR, and 46% of all physicians reported participating in a delivery system reform program. Of those physicians participating in a delivery reform program in 2015, 90% reported using a certified EHR. Of all physicians not participating in a program in 2015, 68% reported using a certified EHR, a statistically significant difference. Nearly all Patient-Centered Medical Home participants (94%) reported use of a certified EHR, the highest rate among delivery reform participants.

Health Care Professional EHR Vendors

Certified Health IT Vendors and Editions Reported by Ambulatory Health Care Professionals Participating in the Medicare EHR Incentive Program

July 2016



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Questions

Angela Jordan, CPC, COBGC, AAPC Fellow

ajordan@thescbi.com

www.soerriescodingandbilling.com



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Thank you!