Emergency Medicine Documentation and Coding for NPs/PAs at Long Beach Memorial

Peter Milano, MD

Emergency Physician

Long Beach Memorial Medical Center

April 8th, 2015

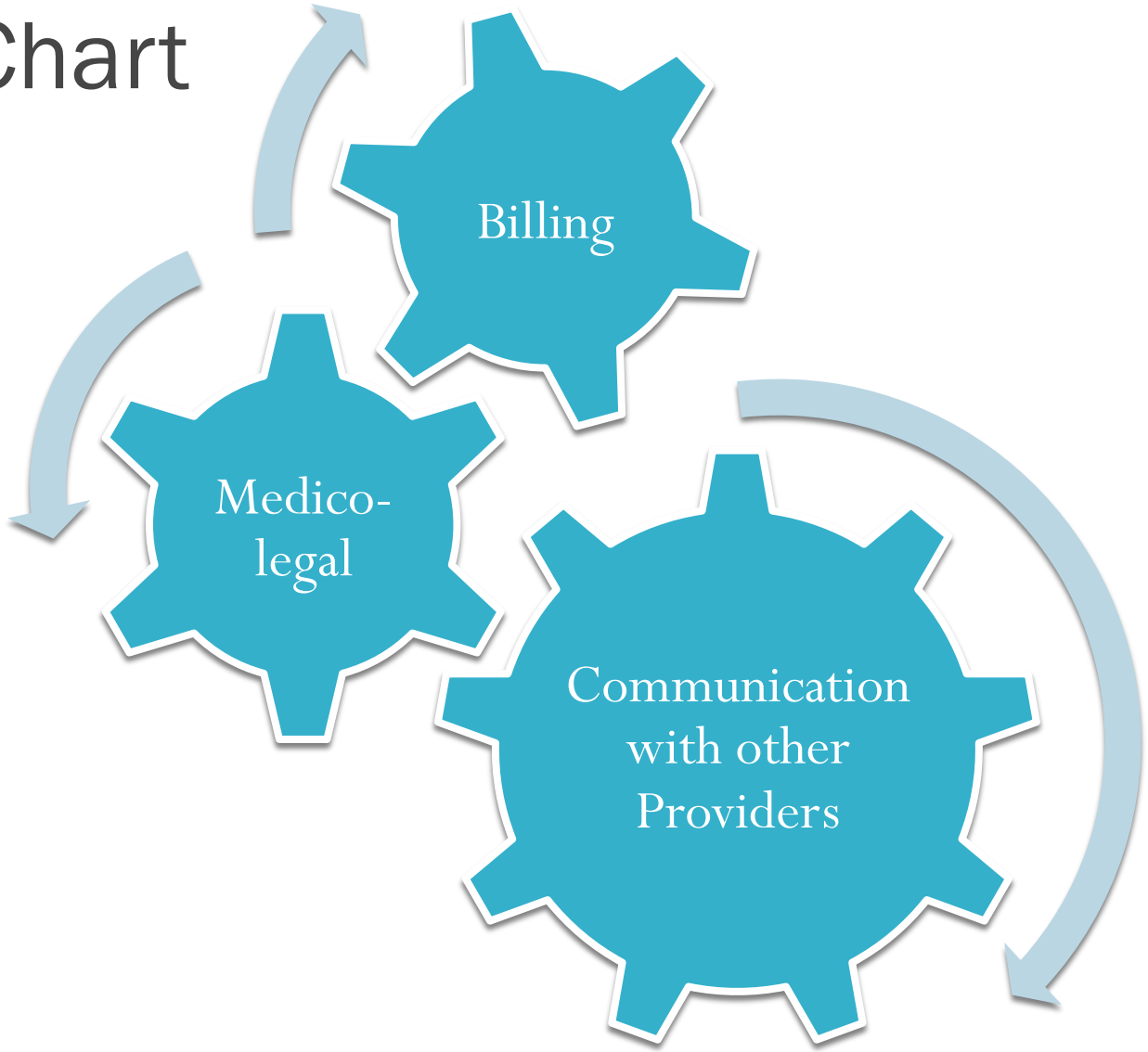
NP/PA Quarterly Educational Meeting

Goals:

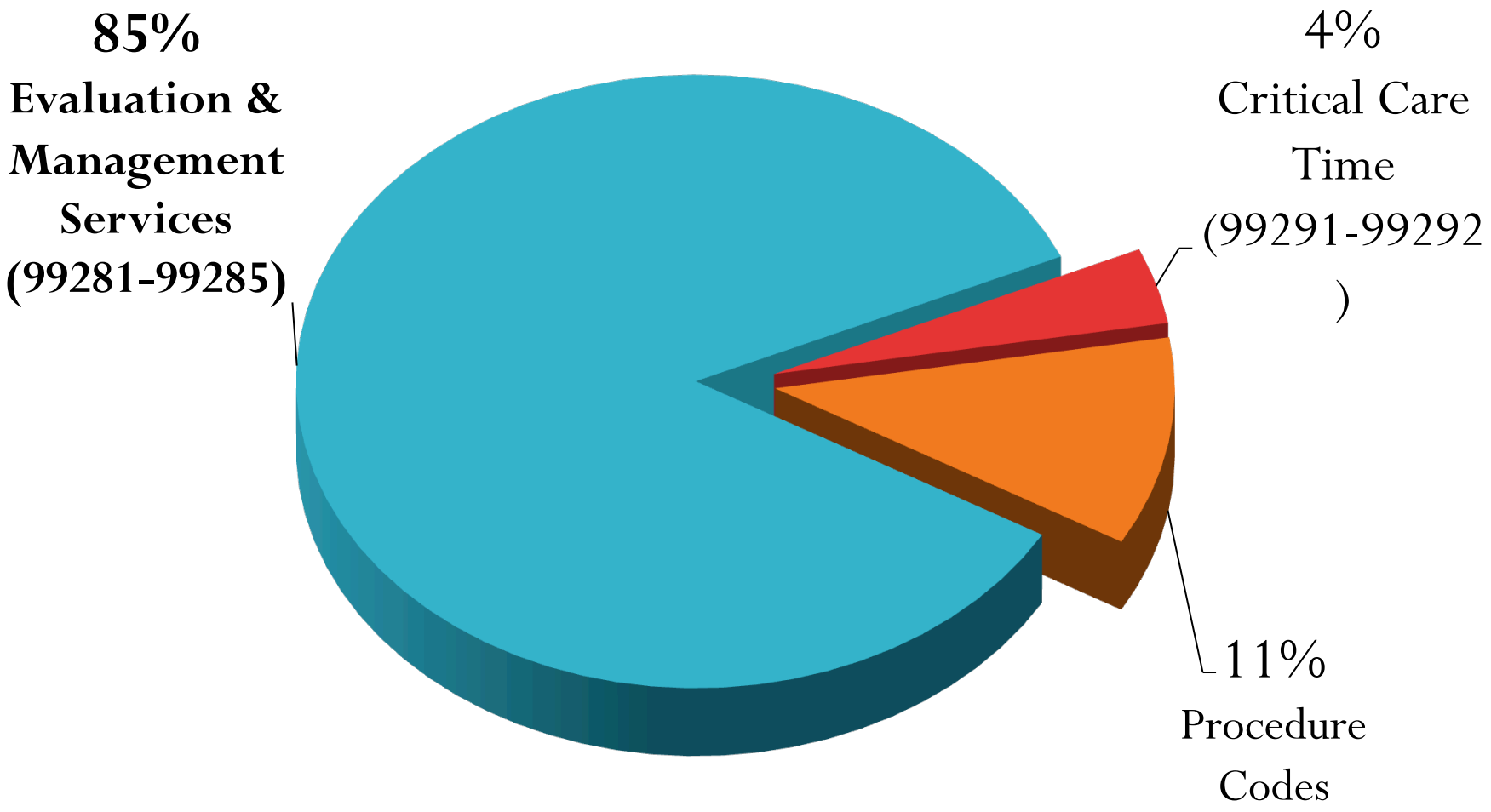
- Overview of emergency medicine coding
- For Level 5 charts, discuss how to:
  - Convey severity of presenting problem (to even qualify for a level 5)
  - Capture complexity of decision making & management
  - Fulfill basic requirements (e.g. HPI elements)
- Critical care time
- EKG interpretations
- Procedure Notes:
  - Lacerations
  - Abscess I&Ds
  - Splints
  - Other WO Procedures
- PQRS: Screening for High Blood Pressure

Overview

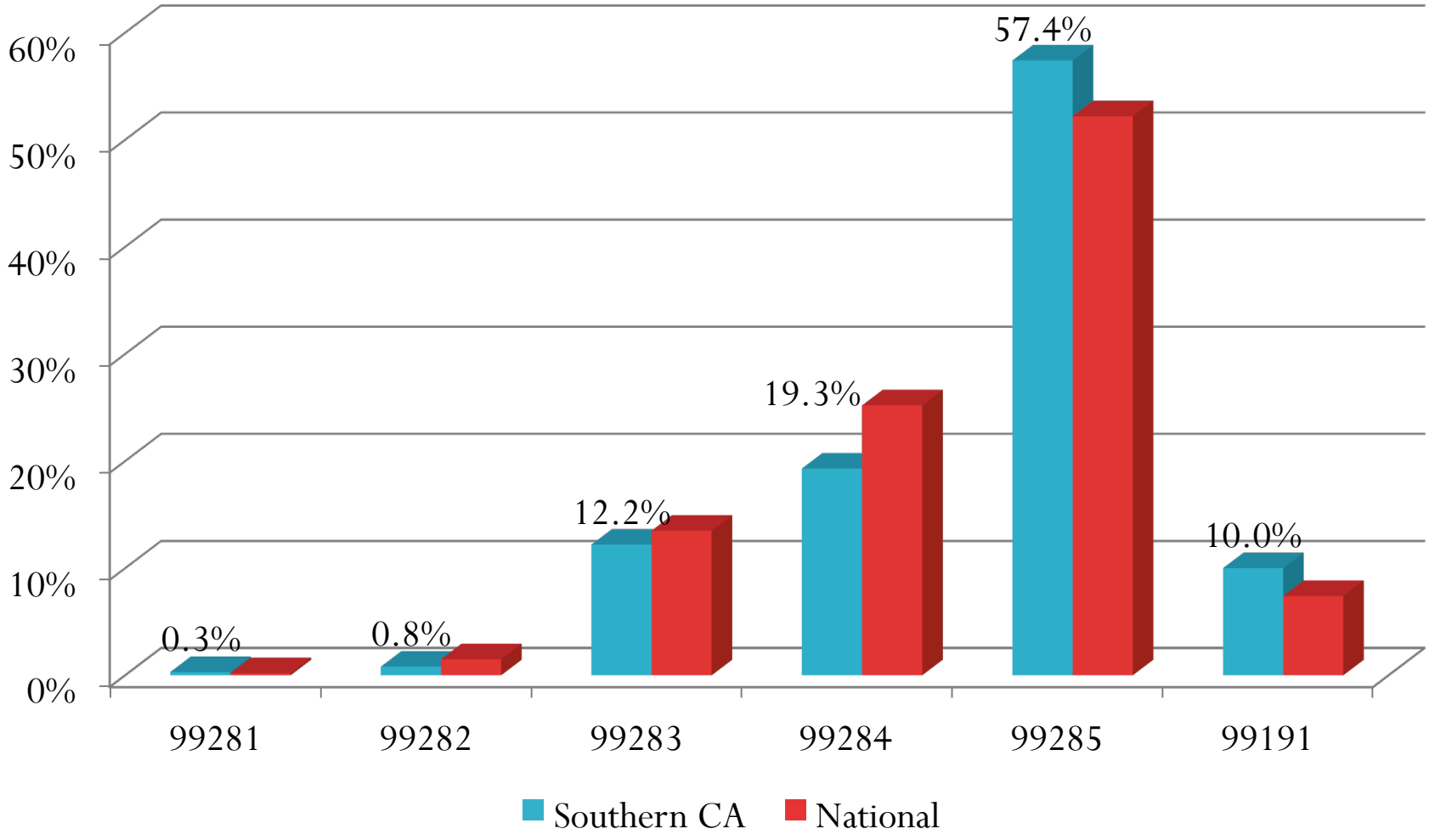
The ED Chart



ED Provider Revenue

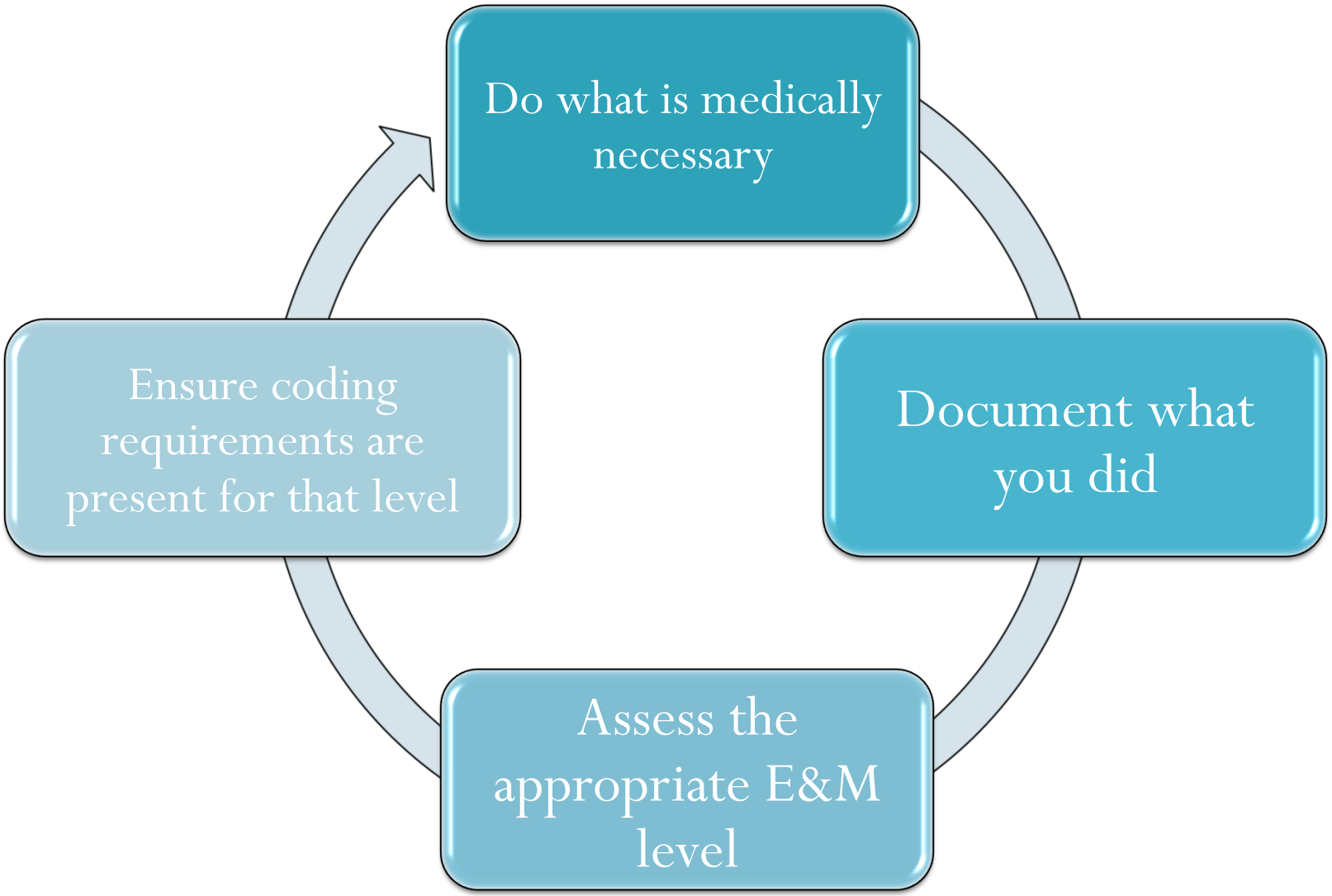


2013 CMS Medicare Acuity Distribution



		99283	99284	99285
Nature of Presenting Problem (NOPP)		Moderate severity	High severity requiring urgent evaluation by provider	High severity with immediate threat to life or physiologic function
History	**HPI**	1	**4**	4
	ROS	1	2	10
	PFSH	0	1	2
Exam		2	5	8
MDM	**Dx or Tx Options**	Moderate Complexity		High Complexity
	Data Review			
	Risk			
	* Need to meet all requirements in a column			

Charting with Consideration for Coding

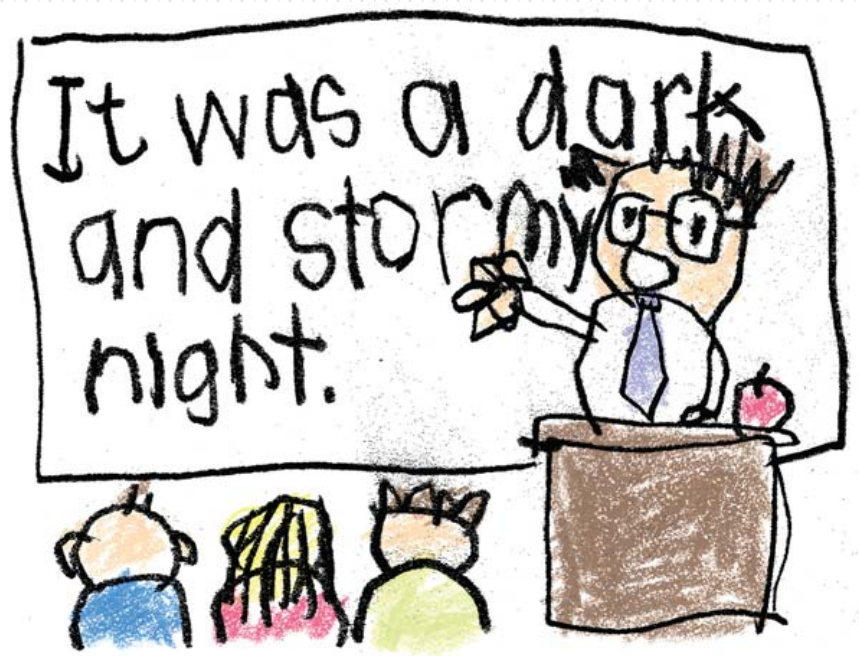


The Level 5 Chart

High severity with immediate threat to life or physiologic function

The Level 5 Chart

History of Present Illness (HPI)



HPI

- Include at least 4 elements (for level 4 & 5)
  - Location
  - Context
  - Quality
  - Timing
  - Severity
  - Duration
  - Modifying Factors
  - Associated Signs and Symptoms
- Convey the severity of the nature of the presenting problem (to justify a level 5 chart in the first place)

HPI

- Pain
  - Location- LUQ, right wrist
  - Context- while eating breakfast, while on the bus, recently missed dialysis
  - Quality- burning, aching, dull, sharp
  - Timing- constant, intermittent, sudden in onset
  - Severity- can be "mid/moderate/severe", numerical pain scale, temperature measurement, lab value
  - Duration- the time it has been going on (sec, min, hours, days)
  - Modifying Factors- anything that makes it better or worse
  - Associated Signs and Symptoms- brief pertinent ROS (no min length requirement)

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LOCATES Mnemonic

Location

Other=Associated Signs & Symptoms

Character=Quality

Aggravating/Alleviating=Modifying Factors

Timing & Duration

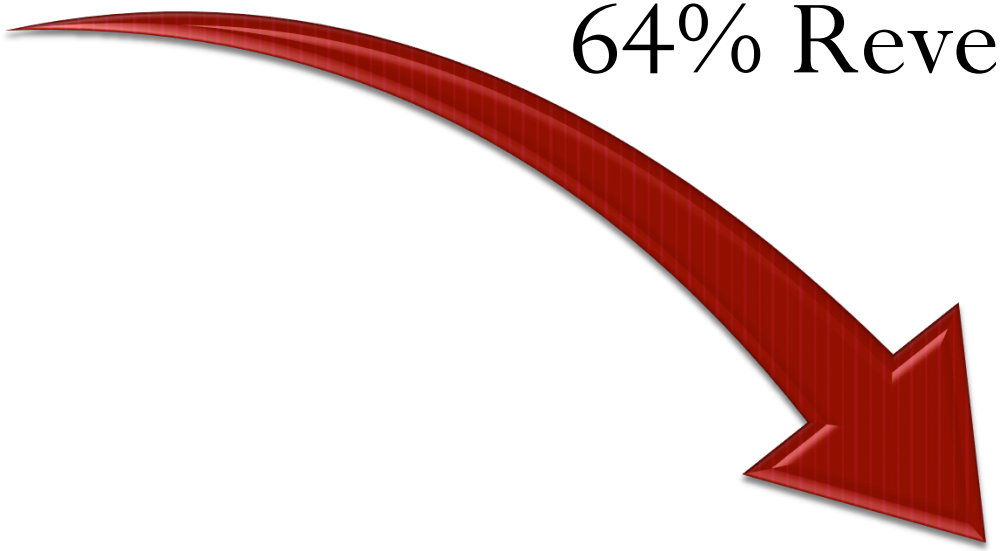
Environment=Context

Severity

3 HPI Elements on an High Acuity Admit

Level 5

4.93 RVU



64% Revenue Loss!

Level 3

1.75 RVU

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Exam		2	5	8
MDM	**Dx or Tx Options**	Moderate Complexity		High Complexity
	Data Review			
	Risk			
	* Need to meet all requirements in a column			

HPI Example- Golf Chest Pain

45 yo M smoker with a history of HTN and DM presents with chest pain which started about 2 hours ago. He was golfing a walking with his bag a clubs when it started. He describes it as a tightness. He rested and it went away after 20 minutes. He felt nauseous but not short of breath. He then continued to play until the game was finished, then told his wife about the event when he got home and she insisted he come in for evaluation.

- ❑ Location
- ❑ Context
- ❑ Quality
- ❑ Timing
- ❑ Severity
- ❑ Duration
- ❑ Modifying Factors
- ❑ Associated Signs and Symptoms

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- ✓ Context
- ✓ Quality
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- ❑ ~~Severity~~
- ✓ Duration
- ❑ ~~Modifying Factors~~
- ✓ Associated Signs and Symptoms

HPI Example- STEMI-like Chest Pain

45 yo M smoker with a history of HTN and DM presents with chest pain. His cardiologist is Dr. Heart. He had a STEMI in 2011 with a stent placement in the LAD, and then in 2013 had two stents placed in the RCA after continuing to have pain. He last saw Dr. Heart about 2 months ago and had a negative stress test. He is on plavix and reports he has been compliant with this. He does not have any history of DVT or PE. He describes the pain as similar to his MI.

- ❑ Location
- ❑ Context
- ❑ Quality
- ❑ Timing
- ❑ Severity
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- ❑ ~~Severity~~
- ❑ ~~Duration~~
- ❑ ~~Modifying Factors~~
- ❑ ~~Associated Signs and Symptoms~~

HPI Example- Headache

50 yo M with a history of a cerebral aneurysm s/p clipping after subarachnoid hemorrhage in 2008 presents with a headache. He has had follow up since then with Dr. Neurosurgeon. When he initially had the hemorrhage he had a complicated hospital course during which he developed ventilator associated pneumonia and renal failure. He was doing well since then until this early this morning, about 8 hours ago, when he developed another sudden onset headache. He call Dr. Neurosurgeon and she said to come to the ED immediately, but he says he had to wait for his friend to come pick up his dog first because he figures he would be admitted.

- ❑ Location
- ❑ Context
- ❑ Quality
- ❑ Timing
- ❑ Severity
- ❑ Duration
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- ❑ ~~Quality~~
- ✓ Timing
- ❑ ~~Severity~~
- ✓ Duration
- ❑ ~~Modifying Factors~~
- ❑ ~~Associated Signs and Symptoms~~

HPI Example- Vaginal Bleeding

40 yo F presents with vaginal bleeding. She has a history of uterine fibroids and is awaiting a hysterectomy with her outside gynecologist. The bleeding has been going on for about 2 months, but has been much more rapid for 6 hours. She reports she is constantly bleeding now and soaking a pad every 30 minutes. She reports that she feels weak and dizzy. There has been bright red blood and clots.

- ❑ Location
- ❑ Context
- ❑ Quality
- ❑ Timing
- ❑ Severity
- ❑ Duration
- ❑ Modifying Factors
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- ✓ Context
- ❑ ~~Quality~~
- ✓ Timing
- ❑ ~~Severity~~
- ✓ Duration
- ❑ ~~Modifying Factors~~
- ✓ Associated Signs and Symptoms

HPI Example- History Caveat

40 yo M with unknown past medical history is brought in by ambulance after being found down downtown.

Unable to obtain further history given patients altered level of consciousness, and the patient had no wallet and we have are therefore unable to obtain collateral information.

- ❑ Location
- ❑ Context
- ❑ Quality
- ❑ Timing
- ❑ Severity
- ❑ Duration
- ❑ Modifying Factors
- ❑ Associated Signs and Symptoms

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- ~~Context~~
- ~~Quality~~
- ~~Timing~~
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- ~~Duration~~
- ~~Modifying Factors~~
- ~~Associated Signs and Symptoms~~

History Caveat

- "*If the [provider] is unable to obtain a history from the patient or other source, the record should describe the patient's condition or other circumstances which precludes obtaining a history*" (CMS 1995 Documentation Guidelines)
- 3 requirements*:
  - REASON you were not able to obtain a complete history from the patient
  - PROOF OF EXHAUSTING other sources of history
  - SOURCE of the history that you were able to obtain

*[per Physician's Choice Documentation Review 2/11/2015]

Acuity Caveat

- *"Within the constraints imposed by the urgency of the patient's clinical condition and/or mental status"*
- Can be used for HPI, ROS and even (more rarely) exam.

HPI Example- EHR Template

This is a 65 year old man who presents with dizziness. The duration is 1 day. The timing is constant. The modifying factors are none. The severity is moderate.

- ❑ Location
- ❑ Context
- ❑ Quality
- ❑ Timing
- ❑ Severity
- ❑ Duration
- ❑ Modifying Factors
- ❑ Associated Signs and Symptoms

HPI Example- EHR Template

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- ❑ ~~Location~~
- ❑ ~~Context~~
- ❑ ~~Quality~~
- ✓ Timing
- ✓ Severity
- ✓ Duration
- ✓ Modifying Factors
- ❑ ~~Associated Signs and Symptoms~~

HPI Example- Mix & Match

65 yo M smoker with a hx of HTN presents with chest pain and weakness. The chest pain was sudden in onset and tearing in quality. He also noticed weakness in his left arm. This weakness is mild, but noticeable to him.

- ❑ Location
- ❑ Context
- ❑ Quality
- ❑ Timing
- ❑ Severity
- ❑ Duration
- ❑ Modifying Factors
- ❑ Associated Signs and Symptoms

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- ✓ Location
- ❑ ~~Context~~
- ✓ Quality
- ✓ Timing
- ✓ Severity
- ❑ ~~Duration~~
- ❑ ~~Modifying Factors~~
- ❑ ~~Associated Signs and Symptoms~~

HPI Example- Abnormal Lab

80 yo F with a history of myelodysplastic syndrome is referred by her PMD for a low hemaglobin. She gets transfusions about every 2 months. She is a symptomatic. Her doctor draws her blood counts every month, and her hemaglobin on routine lab draw 2 days ago was 5.2. She is asymptomatic, and denies fatigue, lightheadedness or shortness of breath.

- ❑ Location
- ❑ Context
- ❑ Quality
- ❑ Timing
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- ❑ Duration
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- ❑ ~~Location~~
- ✓ Context
- ❑ ~~Quality~~
- ❑ ~~Timing~~
- ✓ Severity
- ✓ Duration
- ❑ ~~Modifying Factors~~
- ✓ Associated Signs and Symptoms

Other challenging CCs

- Overdose
  - Location:
  - Context: recent breakup with boyfriend
  - Quality:
  - Timing: ingestion took placed 2 hours ago
  - Severity: took 100 pills of acetaminophen
  - Duration:
  - Modifying Factors:
  - Associated Signs and Symptoms: No abdominal pain

Other challenging CCs

- Cough
  - Location:
  - Context: getting over the flu
  - Quality: productive of green sputum
  - Timing:
  - Severity: moderate
  - Duration: 3 days
  - Modifying Factors: worse with deep breaths
  - Associated Signs and Symptoms: shortness of breath & fever

Other challenging CCs

- Shortness of breath
  - Location
  - Context: history of asthma
  - Quality:
  - Timing: constant
  - Severity: severe
  - Duration: progressive for 3 days, much worse today
  - Modifying Factors: improved with albuterol inhalers
  - Associated Signs and Symptoms: no fevers

Other challenging CCs

- Syncope
  - Location:
  - Context: Singing at church
  - Quality: per bystanders, patient's eyes rolled back and he collapsed to the floor
  - Timing:
  - Severity:
  - Duration: unresponsive for 2 minutes
  - Modifying Factors:
  - Associated Signs and Symptoms: no preceding palpitations, shortness of breath, chest pain or headache

Other challenging CCs

- Weakness (focal)
  - Location: right arm
  - Context: started while eating breakfast
  - Quality:
  - Timing: started suddenly
  - Severity: able to lift arm, but noticed unable to grip coffee cup
  - Duration: 30 minutes
  - Modifying Factors: none
  - Associated Signs and Symptoms: slurred speech, facial droop, numbness

Other challenging CCs

- Weakness (generalized)
  - Location: generalized
  - Context: food poisoning with copious vomiting and diarrhea
  - Quality:
  - Timing: constant
  - Severity: moderate
  - Duration: progressive over 3 days, worse today
  - Modifying Factors: none
  - Associated Signs and Symptoms: dry mouth, lightheadedness

Other challenging CCs

- Trauma
  - Complains of pain
  - Location: chest wall
  - Context: high speed unrestrained MVC
  - Quality: aching
  - Timing: constant
  - Severity: severe
  - Duration: 30 minutes
  - Modifying Factors: worse with movement
  - Associated Signs and Symptoms: shortness of breath

The Level 5 Chart

Review of Systems (ROS)

		99283	99284	99285
Nature of Presenting Problem (NOPP)		Moderate severity	High severity requiring urgent evaluation by provider	High severity with immediate threat to life or physiologic function
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	Risk			
	* Need to meet all requirements in a column			

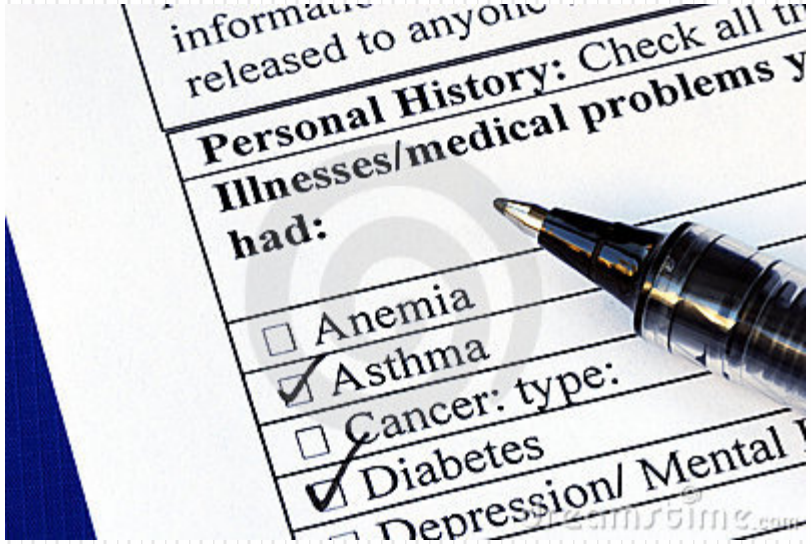
Review of Systems (ROS)

- Complete ROS = 10 systems
- No minimum requirements for # of elements in each system
  - ie "CV: no chest pain" counts
- "CV: negative" also counts
- "CV: see HPI" counts, (if you review the system in the HPI)
- "All other systems reviewed and negative"
- Make sure ROS doesn't contradict HPI

1. Constitutional
2. Eyes
3. ENT
4. Cardiovascular
5. Respiratory
6. Gastrointestinal
7. Genitourinary
8. Musculoskeletal
9. Integumentary
10. Neurological
11. Psychiatric
12. **Endocrine**
13. Hematologic/Lymphatic
14. **Allergy**/Immunologic

The Level 5 Chart

Past Medical, Family History & Social History (PFSH)



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Past Medical, Family History & Social History (PFSH)

- A "complete" PFSH (for level 5) is 2/3
- Allergies/medications/past medical history and past surgical history all count just for Past Medical
- There are no minimum requirements for any of these
  - "not a smoker" counts as a social history

  (although it may not be medically adequate sometimes)
- "FHx: noncontributory" does not count
- Verify completion by nursing!

The Level 5 Chart

Physical Exam

Physical Exam

- No minimum requirements for number of elements in each system
- Endocrine and Allergy from ROS not on this list
- Don't fall short of 8 exam elements because your making up sections that don't count

Organ Systems (12)

- ❑ General
- ❑ Eyes
- ❑ ENT
- ❑ Cardiovascular
- ❑ Respiratory
- ❑ Gastrointestinal
- ❑ Genitourinary
- ❑ Musculoskeletal
- ❑ Skin
- ❑ Neurologic
- ❑ Psychiatric
- ❑ Heme/Lymphatic/Immunologic

Physical Exam

- No minimum requirements for number of elements in each system
- Endocrine and Allergy from ROS not on this list
- Don't fall short of 8 exam elements because your making up sections that don't count

Body Areas

- ❑ Head/Face
- ❑ Neck
- ❑ Chest
- ❑ Abdomen
- ❑ Genitalia (includes groin and buttocks)
- ❑ Back
- ❑ Each extremity

The Level 5 Chart

MDM

The idea here is to learn what charting elements are important to coders

NOT for you to calculate Data Review points and refer to a Risk Table for each case!

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Medical Decision Making (MDM)

Must meet or exceed 2/3	Moderate Complexity	High Complexity
Diagnostic or Treatment Options	3 = New problem, no additional workup planned	4 = New problem, additional workup planned
Data review	3	4
Risk	Moderate	High

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MDM - Data Review

Complexity of Data Ordered/Reviewed	Max4
Review and/or order of clinical lab test	1
Review and/or order of radiology tests	1
Review and/or order EKG	1
Discussion of test results with performing physician [*or*] Decision to obtain old records [*and/or*] Decision to obtain history from someone other than patient	1
Discussion of case with another health care provider [*and/or*] Review and **summarization of old records** [*and/or*] Obtaining **history from someone other than patient**	2
Independent **visualization** of imaging, tracing or specimen itself (not simply review of a report)	2

MDM - Data Review

Especially valuable to document your summary of old records if you did not discuss the case with another health care provider.

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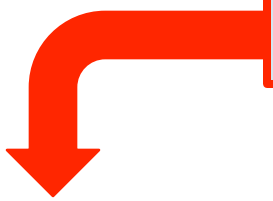

MDM - Risk

TABLE C Table of Risk

Level of Risk	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
Minimal	• One self-limited or minor problem, e.g., cold, insect bite, tinea corporis	• Laboratory tests requiring venipuncture • Chest x-rays • EKG/EEG • Urinalysis • Ultrasound, e.g., echocardiography • KOH prep	• Rest • Gargles • Elastic bandages • Superficial dressings
Low	• Two or more self-limited or minor problems • One stable chronic illness, e.g., well-controlled hypertension, non-insulin dependent diabetes, cataract, BPH • Acute uncomplicated illness or injury, e.g., cystitis, allergic rhinitis, simple sprain	• Physiologic tests not under stress, e.g., pulmonary function tests • Non-cardiovascular imaging studies with contrast, e.g., barium enema • Superficial needle biopsies • Clinical laboratory tests requiring arterial puncture • Skin biopsies	• Over-the-counter drugs • Minor surgery with no identified risk factors • Physical therapy • Occupational therapy • IV fluids without additives
Moderate	• One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment • Two or more stable chronic illnesses • Undiagnosed new problem with uncertain prognosis, e.g., lump in breast • Acute illness with systemic symptoms, e.g., pyelonephritis, pneumonitis, colitis • Acute complicated injury, e.g., head injury with brief loss of consciousness	• Physiologic tests under stress, e.g., cardiac stress test, fetal contraction stress test • Diagnostic endoscopies with no identified risk factors • Deep needle or incisional biopsy • Cardiovascular imaging studies with contrast and no identified risk factors, e.g., arteriogram, cardiac catheterization • Obtain fluid from body cavity, e.g., lumbar puncture, thoracentesis, culdocentesis	• Minor surgery with identified risk factors • Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors • Prescription drug management • Therapeutic nuclear medicine • IV fluids with additives • Closed treatment of fracture or dislocation without manipulation
High	• One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment • Acute or chronic illnesses or injuries that pose a threat to life or bodily function, e.g., multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure • An abrupt change in neurologic status, e.g., seizure, TIA, weakness, sensory loss	• Cardiovascular imaging studies with contrast with identified risk factors • Cardiac electrophysiological tests • Diagnostic Endoscopies with identified risk factors • Discography	• Elective major surgery (open, percutaneous or endoscopic) with identified risk factors • Emergency major surgery (open, percutaneous or endoscopic) • Parenteral controlled substances • Drug therapy intensive requiring monitoring for toxicity • Decision not to resuscitate or to de-escalate care because of poor prognosis

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Minimal	• One self-limited or minor problem, e.g., cold, insect bite, tinea corporis	• Laboratory tests requiring venipuncture • Chest x-rays • EKG/EEG • Urinalysis • Ultrasound, e.g., echocardiography • KOH prep	• Rest • Gargles • Elastic bandages • Superficial dressings
Low	• Two or more self-limited or minor problems • One stable chronic illness, e.g., well-controlled hypertension, non-insulin dependent diab cataract, BPH • Acute uncomplicated il injury, e.g., cystitis, simple sprain	• Physiologic tests not under stress, e.g., pulmonary function tests • Non-cardiovascular imaging studies with contrast, e barium enema • Superficial needle Clinical laborato uiring arte iops	• Over-the-counter drugs • Minor surgery with no identified risk factors • Physical therapy • Occupational therapy • IV fluids without additives
Moderate	• One or more chro with mild exacerbat progression, or side e treatment • Two or more stable chronic illnesses • Undiagnosed new problem wi uncertain prognosis, e.g., breast • Acute illness with syst symptoms, e.g., pv pneumonitis, col • Acute complica head injury with consciousness	l biopsy tudies ed	Minor surgery with identified risk factors • Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors • Prescription drug management • Therapeutic nuclear medicine • IV fluids with additives • Closed treatment of fracture or dislocation without manipulation
High	• One or more chronic ill with severe exacerbation, progression, or side effects treatment • Acute or chronic illnesses or injuries that pose a threat to life or bodily function, e.g., multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure • An abrupt change in neurologic status, e.g., seizure, TIA, weakness, sensory loss	• Cardiovascular ima studies with contrast identified risk factors • Cardiac electrophysiological tests • Diagnostic Endoscopies with identified risk factors • Discography	• Elective major surgery (open, percutaneous or endoscopic) with identified risk factors • Emergency major surgery (open, percutaneous or endoscopic) • Parenteral controlled substances • Drug therapy intensive requiring monitoring for toxicity • Decision not to resuscitate or to de-escalate care because of poor prognosis

MDM-Risk	Presenting Problem	Management Options
Moderate	• One or more chronic illnesses with mild exacerbation • Two or more stable chronic illnesses • Undiagnosed new problem with uncertain prognosis • **Acute illness with systemic symptoms** e.g. pyelonephritis, pneumonitis, colitis • **Acute complicated injury** e.g. head injury with brief loss of consciousness	• Minor Surgery with identified risk factors • **Prescription drug management** • **IV fluids with additives** • **Closed treatment of fracture** or dislocation without manipulation
High	• One or more chronic illnesses with **severe exacerbation** • **Acute or chronic illnesses or injuries that pose a threat to life or bodily function** e.g. multiple trauma, acute MI, PE, severe respiratory distress, psychiatric illness with DTS/DTO, peritonitis, acute renal failure • **An abrupt change in neurologic status** e.g. seizure, TIA, weakness, sensory loss	• Emergency major **surgery** • **Parenteral controlled substances** • **Drug therapy requiring monitoring for toxicity** • **Decision not to resuscitate or to de-escalate care** because of poor prognosis

		99283	99284	99285
Nature of Presenting Problem (NOPP)		Moderate severity	High severity requiring urgent evaluation by provider	High severity with immediate threat to life or physiologic function
History	**HPI**	1-3	**4**	4
	ROS	1	2	10
	PFSH	0	1	2
Exam		2	5	8
MDM *need 2/3*	**Dx or Tx Options**	No additional w/u planned		Additional w/u planned
	Data Review	3 Points		4 Points
	Risk	Moderate		High

				99285
Nature of Presenting P (NOPP)				gh severity h immediate eat to life or hysiologic function
History	H			4
	R			10
	PF			2
Exam				8
MDM *need 2/3*	Dx Opt			dditional u planned
	Data F			4 Points
	Ri			High

Complex and subjective—not just to you

J Fam Pract. 2000 Jul;49(7):642-5.

Variability in code selection using the 1995 and 1998 HCFA documentation guidelines for office services. Health Care Financing Administration.

Zuber TJ[1], Rhody CE, Muday TA, Jackson EA, Rupke SJ, Francke L, Rathkamp WT.

Author information

[1]Department of Family Medicine, Saginaw Cooperative Hospitals and Michigan State University, 48602, USA. zuber@pilot.msu.edu

Abstract

BACKGROUND: Documentation guidelines have been developed by the Health Care Financing Administration (HCFA) to promote consistent selection of physician evaluation and management (E & M) codes. Our goals were to determine whether medical providers and auditors agree in their assignment of office codes using 1995 and 1998 guidelines and to ascertain if the code levels assigned are affected by auditor experience and training.

METHODS: A total of 1,069 established patient charts from private family physician offices were reviewed by a family practice faculty physician, a family practice resident physician, and a professional coder. The main outcome measures were the agreement between the auditors and the medical care provider on code selection and the degree to which documentation supported the code selected.

RESULTS: All auditors agreed with the medical provider code selection in only 15.2% (1995 guidelines) and 29.2% (1998 guidelines) of visits. Professional coders were more likely than faculty physicians or resident physicians to agree with the code assigned by the medical provider (51.7% vs 40.7% and 39.6%, P <.001). Documentation adequately supported the most common office code selection, 99213, in 92.7% (1995) and 91.0% (1998) of the charts reviewed. Concurrence among all auditors was only 31.0% (1995) and 44.3% (1998).

CONCLUSIONS: Interobserver differences exist in the assignment of E & M codes by auditors using both 1995 and 1998 HCFA guidelines. The 1998 documentation guidelines produce greater agreement among auditors. The documentation supported the level of code billed in the majority of established patient office visits.

PMID: 10923576 [PubMed - indexed for MEDLINE]

Complex and subjective—not just to you

Arch Intern Med. 2002 Feb 11;162(3):316-20.

Expert agreement in Current Procedural Terminology evaluation and management coding.

King MS[1], Lipsky MS, Sharp L.

⊕ **Author information**

Abstract

BACKGROUND: Available data suggest that physicians are accurate in approximately 55% of Current Procedural Terminology (CPT) evaluation and management (E/M) coding for their services. This accuracy is relative to observers' or auditors' assigned codes for these services, a group that has not been studied for their consistency in application of the CPT E/M coding guidelines. The purpose of this study was to determine the level of agreement of certified coding specialists in their application of CPT E/M coding guidelines.

METHODS: Three hundred certified professional coding specialists randomly selected from the active membership of the American Health Information Management Association were sent 6 hypothetical progress notes of office visits along with a demographic survey. The study group assigned CPT E/M codes to each of the progress notes and completed the demographic survey.

RESULTS: Coding specialists agreed on the CPT E/M codes for 57% of these 6 cases. The level of agreement for the individual cases ranged from 50% to 71%. Relative to the most common or consensus code, undercoding of established patients occurred more commonly than overcoding. In contrast, for new patient progress notes, overcoding relative to the consensus code was more common than undercoding.

CONCLUSIONS: There is substantial disagreement among coding specialists in application of the CPT E/M coding guidelines. The results of this study are similar to results of prior studies assessing physician coding accuracy, suggesting that the CPT coding guidelines are too complex and subjective to be applied consistently by coding specialists or physicians.

PMID: 11822924 [PubMed - indexed for MEDLINE]

Remember...

The idea here is to learn what charting elements are important to coders

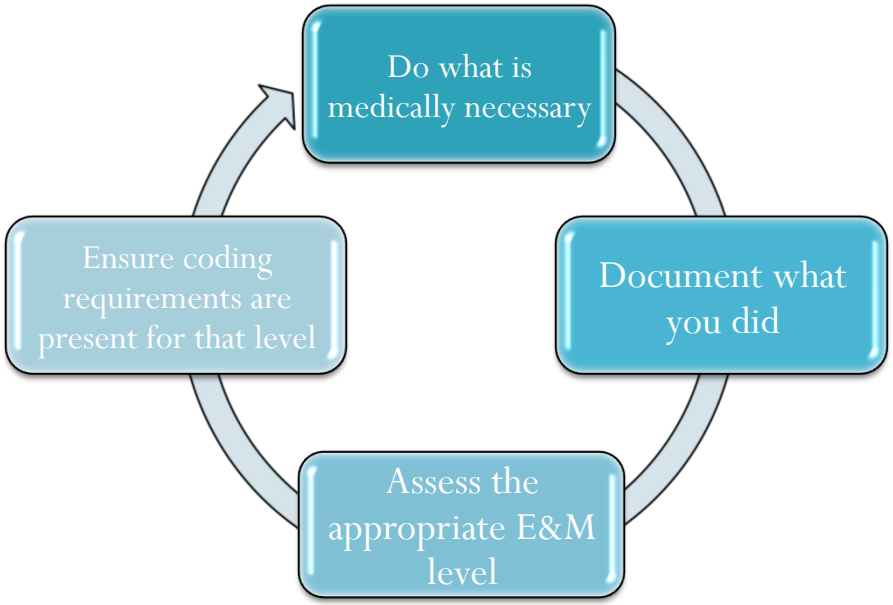
NOT for you to calculate Data Review points and refer to a Risk Table for each case!

Nature of Presenting Problem (NOPP)

- In the words of Medicare:

"Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code"

- The NOPP will also normally determine the extent of the history and exam that is required.



Communicating NOPP

- Impress upon the reader the severity of the case, or the complexity of the decision making
  - A rich descriptive HPI
  - Differential diagnosis
  - Progress notes and reassessments
- Case specific ROS
- Case specific physical exam (esp. general appearance)
- Document co-morbidities
- Adjective and descriptors in the final impression to justify urgency of the case (“acute”, “sepsis”, “respiratory distress”)

HPI Example- EHR Template

This is a 65 year old man who presents with dizziness. The duration is 1 day. The timing is constant. The modifying factors are none. The severity is moderate.

- ❑ ~~Location~~
- ❑ ~~Context~~
- ❑ ~~Quality~~
- ✓ Timing
- ✓ Severity
- ✓ Duration
- ✓ Modifying Factors
- ❑ ~~Associated Signs and Symptoms~~

What is the appropriate chart level to shoot for?

	99283	99284	99285
CMS NOPP Definition	Presenting problem(s) are of **moderate severity**	Presenting problem(s) are of **high severity**, and **require urgent evaluation by the physician**	Presenting problem(s) are of high severity and pose an **immediate significant threat to life or physiologic function**
Examples	• Cervicitis without PID or abdominal pain. • Young healthy person with blunt head trauma without LOC, confusion or complicating features • Ankle sprain • Child with gastroenteritis tolerating POs • Eye pain from a ocular foreign body	• PID with abdominal pain • Child with head trauma with LOC who you are documenting consideration of a head CT on. • Elderly female with traumatic hip pain unable to walk • Female with flank pain & hematuria	• Complicated OD • Active upper GI bleeding • MVC arrives immobilized and has symptoms compatible with intra-abdominal injuries • Acute chest pain compatible with ACS/PE • Thunderclap headache • Stroke • Acute febrile illness in an adult associated with SOB and AMS.

Problems with over-documentation (ROS & Exam, mostly)

- Wastes time
- Higher likelihood of internal inconsistencies
- Lots of payer audit focus on overuse of macros, templates and cloning

hdi
Health Data Insights

hms
Medicaid Recovery Audit Contractor

Critical Care Time

When "a critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the patient's condition" (CPT 2012)

Critical Care Time

- There needs to be a hard finding and an intervention.
- Will patient die or deteriorate (soon) if you don't do something?
- ICU admission/OR should be a reminder, but even a discharge could involve critical care time in rapidly reversible conditions.
- At least 30 minutes of provider care outside of separately billable procedures (e.g. CPR, central lines, intubation).
- Time does not have to be continuous.
- Time includes reviewing labs and studies, discussion with family/ consults and documentation.
- Almost everyone in this ED that has an illness that qualifies for critical care time has met the time requirement.

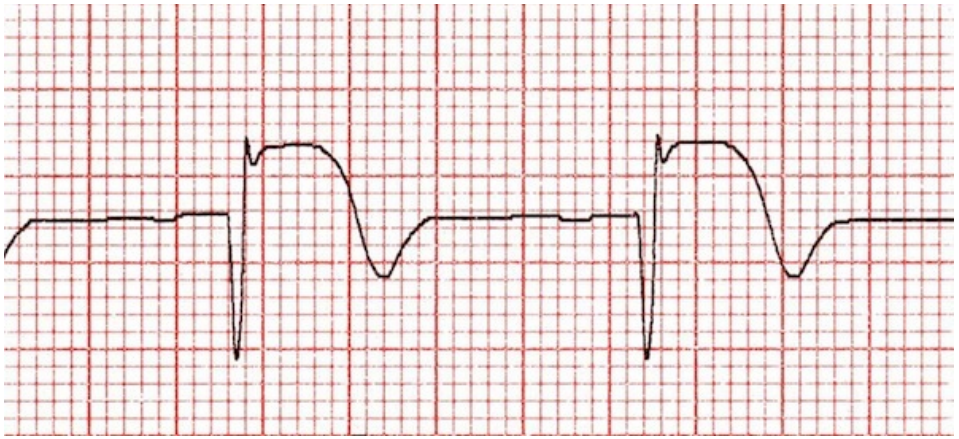
Critical Care Time Examples

	Hard Finding	Intervention
Hyperkalemia	High K	Insulin/D50, emergent HD
DKA	Elevated glucose, acidosis, ketosis	Fluids, insulin
NSTEMI	Elevated troponin	Heparin
Severe sepsis	Hypotension, tachycardia	Fluid Boluses
Ruptured AAA	Intraperitoneal hemorrhage	OR
Chest pain with EKG changes	ST depressions	Nitroglycerin
Afib RVR	Afib RVR	AV nodal blocker
Severe CHF exacerbation	Pulmonary edema on CXR, hypoxia on pulse ox	Nitro gtt, Lasix, CPAP/ BIPAP
Respiratory distress requiring BIPAP or intubation	Hypercarbia, hypoxia, confusion	Airway management
Pneumothorax	Pneumothorax on CXR	Chest tube
Anaphylaxis	Wheeze, hypoxia, rash	Epinephrine
Stroke	Neuro deficit	Lytics considered

Procedures

EKGs

- Each medically necessary EKG interpretation is a separately billable procedure
- Need any 3 of the following elements to constitute an "interpretation and report":
  - Rate/Rhythm
  - Axis
  - Intervals
  - ST/T Waves
  - Comparison to prior
  - Clinical Impression



Lacerations (the 3 L's)

- **Location**

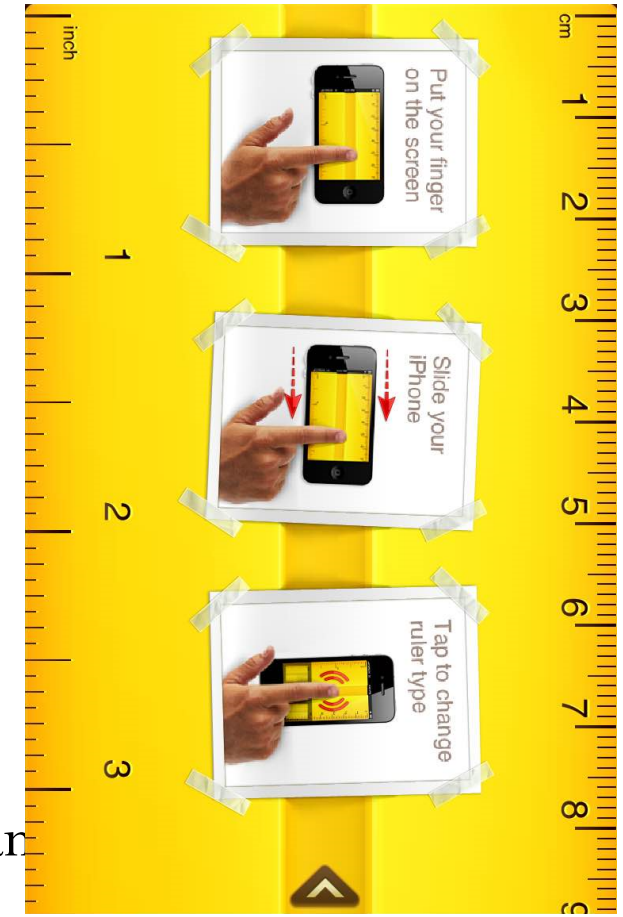
  (~35% difference between scalp & face)

- **Length**
  - Cutoffs
    - 2.6 cm, 5.1 cm, 7.6 cm, 12.6 cm
  - Measure <u>to the millimeter</u>!

  (~25% difference between cutoffs)

- **Layers**
  - Simple- single layer
  - Intermediate- 2 layers or heavily contan
    debridement

  (~30% difference)



Abscess I&Ds

- Simple or single (2.75 RVU)
  - Furuncle, paronychia
  - Superficial
  - Single
- "Complicated" or multiple (5.09 RVU)
  - Probing
  - Loculations
  - Packing

Abscess I&Ds

- Simple or single (2.75 RVU)
  - Furuncle, paronychia
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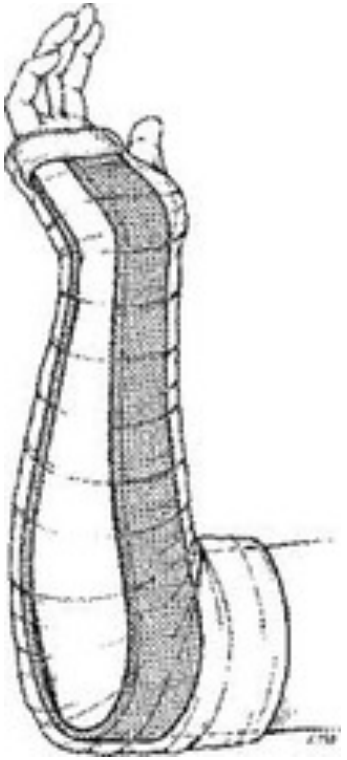
- "Complicated" or multiple (5.09 RVU)
  - Probing
  - Loculations
  - Packing

Level 5 Visit = 4.93 RVU!

Splint Applications

- Pre-fabricated splints, slings, ace wraps do not count
- Full procedure note required:
  - Reason
  - Site
  - Type of splint
  - Technique
  - Pre/Post neurovascular status
  - Who applied



[per Physician's Choice Documentation Review 2/11/2015]

Key Points on other WO Procedures

- **Soft tissue foreign body**
  - Describe depth by level of tissue (subcut, muscle)
  - Dissection?
- **Toenail resection**
  - Wedge excision of the nail fold hypertrophic granulation tissue?
  - Destruction of nail matrix?
- **Ocular foreign body**
  - Slit lamp?
- **Anterior Epistaxis**
  - Limited cautery vs
  - Extensive cautery, or Packing (i.e. RhinoRocket)

Physician Quality Reporting System (PQRS)

On January 19, 2015 CMS released the 2015 Measures Applicability Validation (MAV) process and they identified the following Claims Based MAV for Emergency Care = Cluster 4 + 1 Cross-Cutting Measure:

Cluster 4	Emergency Care	54	Effective Clinical Care	Emergency Medicine: 12-Lead Electrocardiogram (ECG) Performed for Non-Traumatic Chest Pain
		254	Effective Clinical Care	Ultrasound Determination of Pregnancy Location for Pregnant Patients with Abdominal Pain
		255	Effective Clinical Care	Rh Immunoglobulin (Rhogam) for Rh-Negative Pregnant Women at Risk of Fetal Blood Exposure
+	Cross-Cutting	317	Population & Community Health	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented

- Applies to Physician Assistants and Nurse Practitioners
- Only for Medicare patients ≥ 18, no current diagnosis of HTN, not a critical care patient.

Physician Quality Reporting System (PQRS)

- Measure #317: Screening for high blood pressure and follow up documented
  - % of discharged pts ≥ 18yo who were screened and has any single systolic ≥120 and any single diastolic ≥ 80, and were recommended to have follow up.
  - The following dot phrase has been suggested:
    - "This patient has been found to have a BP ≥120/80. I have informed them of the importance of following up with a primary care provider for further evaluation."

Take-Home Points

- For level 5, need 4 HPI elements, even for non-pain-related CCs
- For history caveat, need to exhaust other sources
- Throughout chart, show the severity of the case
- Don't overuse "all other systems reviewed and negative"
- Verify completion of PFSH by nursing
- In the discussion, show the severity & complexity of decision making with ddx & re-assessments
- Include interventions/medications/treatments
  - IV fluids with additives
  - Parenteral controlled substances
  - Drugs requiring drugs monitoring (e.g. fosphenytoin, diltiazem)

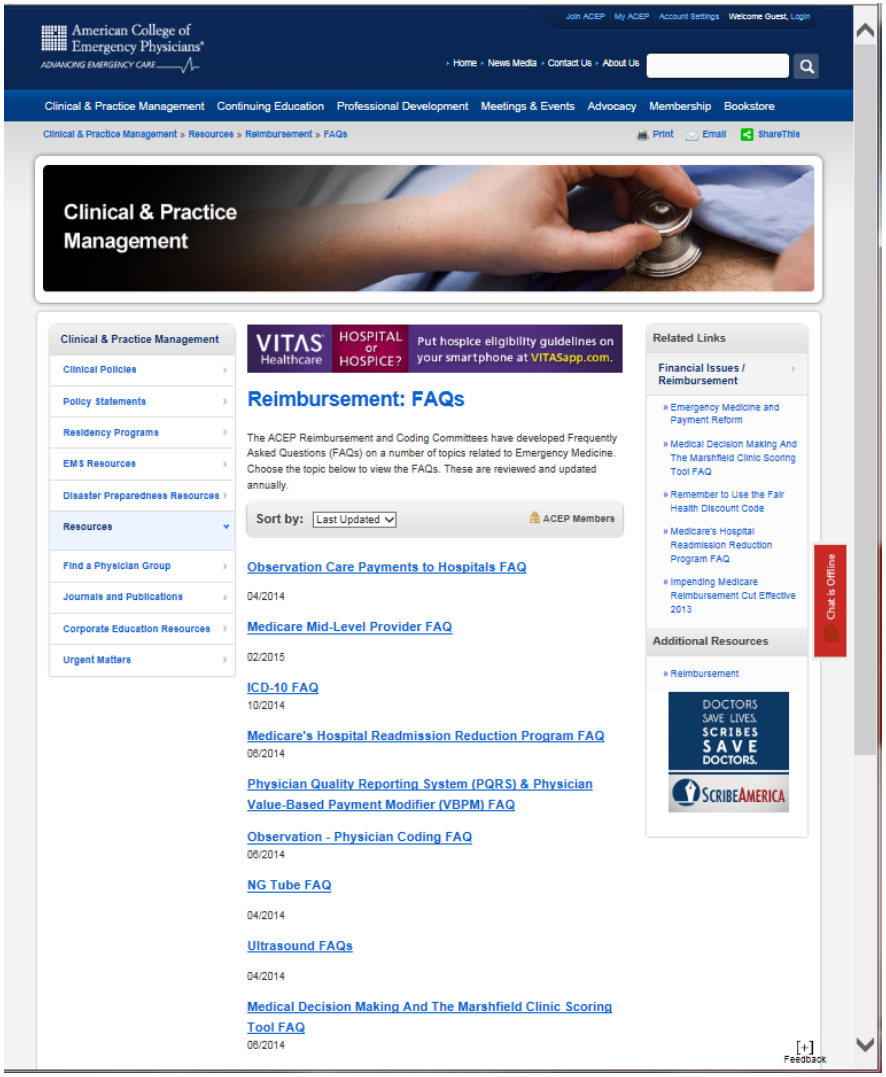
Take-Home Points

- If you do it, document it:
  - Collateral history
  - Summary of old records
  - Discussion of case with radiologist/consultant
  - Re-evaluations
  - Independently reviewed XRs
- Document co-morbidities
- Include discharge prescriptions drugs in provider note
- Document additional work-up planned (especially if DC'ed)

Take-Home Points

- Consider critical care time
- 3 elements for EKG interpretations
- Lacerations:
  - Measure to the millimeter
  - Document layers/contamination/debridement
- I&Ds: Probing, loculations, packing
- Procedure notes for splint applications
- Document diagnosis of "elevated blood pressure" and document follow up when appropriate

Resource:
ACEP Reimbursement Section



peter.milano@gmail.com		99283	99284	99285
Nature of Presenting Problem		Moderate severity	High severity requiring urgent evaluation by provider	High severity with immediate threat to life or physiologic function
History	**HPI**	**1**	**4**	**4**
	ROS	**1**	**2**	**10**
	PFSH	**0**	**1**	**2**
Exam		**2**	**5**	**8**
MDM **Only need 2 out of 3**	**Diagnostic or Treatment Options**	New problem, **no** additional workup planned		New problem, additional workup planned
	Data Review	**3** Points		**4** Points
	Risk	Moderate Risk		High Risk

Data Review

Review and/or order of clinical lab test	1
Review and/or order of radiology tests	1
Review and/or order EKG	1
Discussion of test results with performing physician [*or*] Decision to obtain old records [*and/or*] Decision to obtain history from someone other than patient	1
Discussion of case with another health care provider [*and/or*] Review and **summarization of old records** [*and/or*] Obtaining **history from someone other than patient**	2
Independent visualization of imaging, tracing or specimen itself	2

HPI	Location, Context, Quality, Timing, Severity, Duration, Modifying Factors, Associated Signs and Symptoms
ROS	[Below] + Endo + Allergy/Immuno
Exam	Constitutional/General, Eyes, ENT, CV, Resp, GI, GU, MSK, Skin, Neuro, Psych, Heme/Lymphatic
EKG	Need **3**: Rate/Rhythm, Axis, Intervals, ST/T, Comparison to Prior, Clinical Impression
Lacs	Location, Layers, Length (**2.6**, **5.1**, **7.6**, **12.6** cm)
I&D	"Complicated" = Probing/Loculations/Packing

Risk	Presenting Problem	Management Options
Moderate Risk	• One or more chronic illnesses with mild exacerbation • Two or more stable chronic illnesses • Undiagnosed new problem with uncertain prognosis • **Acute illness with systemic symptoms** e.g. pyelonephritis, pneumonitis, colitis • **Acute complicated injury**, e.g. head injury with brief loss of consciousness	• Minor Surgery with identified risk factors • **Prescription drug management** • **IV fluids with additives** • Closed treatment of fracture or dislocation without manipulation
High Risk	• One or more chronic illnesses with **severe exacerbation** • **Acute or chronic illnesses or injuries that pose a threat to life or bodily function** e.g. multiple trauma, acute MI, PE, severe respiratory distress, psychiatric illness with DTS/DTO, peritonitis, acute renal failure • **An abrupt change in neurologic status** e.g. seizure, TIA, weakness, sensory loss	• Emergency major surgery • **Parenteral controlled substances** • **Drug therapy requiring monitoring for toxicity** • Decision not to resuscitate or to de-escalate care because of poor prognosis

Overall risk level determined by highest risk item

Thank you!

peter.milano@gmail.com

cell (818) 519-6746