New Patient & Consultation Documentation Requirements

SoutheastHEALTH

1. Chief Complaint - Why is the patient here today?
2. History of Present illness
    - Location of the chief complaint
    - Quality of the chief complaint
    - Severity of the chief complaint
    - Duration of the chief complaint
    - Timing of the chief complaint
    - Context of the chief complaint
    - Modifying factors
    - Associated Signs and Symptoms
3. Review of Systems - listed from the patient/office questionnaire
    - Constitutional
    - Eyes
    - Ears, Nose, Throat, Mouth
    - Cardiovascular
    - Respiratory
    - Gastrointestinal
    - Genitourinary
    - Musculoskeletal
    - Integumentary
    - Neurological
    - Psychiatric
    - Endocrine
    - Hematologic/Lymphatic
    - Allergic/Immunologic
4. Physical Exam
    - Organ Systems
        - Constitutional
        - Eyes
        - Ears, Nose, Throat, Mouth
        - Cardiovascular
        - Respiratory
        - Gastrointestinal
        - Musculoskeletal
        - Integumentary
        - Neurological
        - Psychiatric
        - Hematologic/Lymphatic
        - Genitourinary
    - Body Areas
        - Head including face
        - Neck
        - Chest
        - Each Extremity
        - Abdomen
        - Genitalia, groin, buttocks
        - Back including spine
5. Review and ordering of labs
6. Assessment and Plan

New Patient Documentation Requirements

With new patients all **three** elements are required, the history element, the physical exam element and of course the medical decision making.

History element consists of 3 components:

1. History of Present Illness (HPI)
2. Review of Systems (ROS)
3. Past, Family and Social History (PFSH)

There are 4 levels of the history element:

1. Problem Focused which consists of a chief complaint and brief HPI (1-3)
2. Expanded problem focused which consists of a chief complaint, brief HPI

   (1- 3 elements) and a problem pertinent ROS (1 system)
3. Detailed consists of a chief complaint, extended HPI (4 elements) PFSH (1)
4. Comprehensive consists of a CC, extended HPI (4 elements) complete PFSH(3)

There are 4 levels of the exam element:

1. Problem Focused (affected body area or organ system only)
2. Expanded Problem Focused (2-4 body areas or organ systems)
3. Detailed (5-7 body areas or organ systems)
4. Comprehensive (8 or more organ systems)

There are 4 levels of Medical Decision Making:

1. Straightforward
2. Low
3. Moderate
4. High

99241- Problem focused history, Problem focused exam, Straightforward MDM
99242 - Expanded focused history, expanded problem focused exam, Straightforward MDM
99243 - Detailed history, detailed exam and Low MDM
99244 - Comprehensive history, Comprehensive exam and moderate MDM
99245 - Comprehensive history, Comprehensive exam and high MDM

Established Patient Documentation Requirement

Established patient office visits require only 2 of the 3 documentation components. According to CMS the medical decision making of the encounter is always the overarching criteria for the service. So established patient office visits only need the history and MDM to determine the level of service or the physical exam and MDM to determine the level of service.

99212 - Chief complaint, brief history of present illness (1-3 elements) Problem focused exam (1 body area or organ system) Straightforward Medical decision making

99213- Chief complaint, brief HPI (1-3 elements), Problem pertinent ROS {1) Expanded problem focused exam {2-5 organ systems)
Low level MDM

99214- Chief complaint, Extended HPI (4 elements) extended ROS (2-9)1 PFSH element Detailed exam (5-7 organ systems)
Moderate level MDM

99215 - Chief complaint, Extended HPI (4 elements), complete PFSH (3 elements) Comprehensive exam 8+ organ systems
High MDM

History: History of Present Illness

Element	**Examples**
Location - Description or location of the problem	Chest pain = Chest RUQ pain = abdomen
Quality- Characteristics or features of a system (Usually an adjective)	Constant, sharp, radiating, improving, worsening, throbbing, stabbing, mild, severe, moderate, acute, chronic, color
Severity- severity of discomfort, pain or condition	Pain = 5 on a 10 point scale, pain compared to previous experience (labor, kidney stone) documentation of stage of cancer
Duration - Length of time of symptoms	Pain began two days ago, headache for five hours, symptoms began two days before admission
Timing - onset of each symptom and chronology of development	In the morning, after meals, every 3-4 hours, at night, recurring, ongoing
Context - Where patient is or what patient is doing when signs and symptoms occur	Dyspnea upon exertion = upon exertion, shortness of breath when mowing the lawn = when mowing the lawn, pain in wrist when typing = when typing
Modifying Factors - What has been done or attempted to try to obtain relief	Patient took medication such as Tylenol, heat/ice, elevation, went to ER, rested
Associated Signs and Symptoms -Additional sensations or feelings related to the chief complaint	Fever, chills, nausea, vomiting, weakness, blurred vision, diaphoresis, tingling, can also be negative responses no fever denies chills

All HPI elements should be directly related to the patients Chief Complaint!

History: Review of Systems

System	Examples
Constitutional	Fever, Chills, weight loss/gain, appetite, syncope, sleep habits, headache, dizziness polydipsia
Eyes	Glasses, contact lenses, pain, vision, diplopia, itch, dryness, infection, glaucoma
ENTMT: Ears Nose Mouth & Throat	 Pain, deafness, tinnitus, discharge, hearing Bleeding, decrease in sense of smell, dryness, sinusitis, pain, obstruction, discharge Soreness, infection, ulcers, lip lesions, pain, blisters, sore tongue, canker sores, teeth, swallowing, hoarseness, tonsillitis, dysphagia
Cardiovascular	Chest pain, murmurs, angina, palpitations, EKG results, phlebitis, varicosities, claudication
Respiratory	Wheezing, hemoptysis, dyspnea, cough, sputum (color), infection, exposure to TB, asthma, pneumonia, pleurisy, DOE, congestion shortness of breath, orthopnea
Gastrointestinal	Nausea, vomiting, diarrhea, heart burn, belching, food intolerance, change in bowel habits, hematemesis, bloating, hernia, hematochezia; melena, hemorrhoids, constipation, abd pain, history of ulcers
Genitourinary: General Female Male	 Hematuria, frequency, burning, polyuria, incontinence, renal stones inability to start stream, urgency Postmenopausal menorrhagia, cycle, climacteric age, itch, discharge, obstetric gravida, live births, dyspareunia, abortions, vaginal infections, menarche, venereal disease Pain, Skin lesions, venereal disease, testicular pain, discharge, impotence
Musculoskeletal	Pain, weakness, cramps, joint pain, atrophy, fracture, joint swelling, scoliosis, kyphosis, back injury
Lntegumentary Breast	Rash, itch, hair and changes, color change, infections, nail and changes, sores, hives and bruising Discharge, bleeding, retraction, tenderness
Neurologic	Seizures, tremor, vertigo, pain, paralysis, coordination, ataxia, dysesthesia, tics, speech disturbance, memory loss, numbness, tingling, migraine
Psychiatric	Anxiety, thoughts of suicide, depression, delusions, hallucinations, nervousness, emotional instability, tension
Endocrine	Hypothyroid, diabetes, goiter, hyperthyroid
Hematologic/Lymphatic	Anemia, malignancy, bleeding, lymphadenopathy
Allergic/Immunologic	Drug Allergies, food allergies, pet allergies, hay fever, HIV, AIDS

Physical Examination Standards

Body Area/Organ System	Examples
Head, including face	HEENT:normal, NCAT
Neck	NO JVD, supple, no thyromegaly
Chest, including breast and axillae	Sore to the touch, breasts lumps
Abdomen	Non-distended, nontender, no rebounding, no guarding
Genitalia, Groin Buttocks	External genitalia normal
Back, including spine	No back tenderness, no spine tenderness
Each Extremity	No CCE, LE swelling
Constitutional	Vital signs (at least 3), general appearance, looks rested and comfortable
Eyes	HEENT: normal/negative, PERRLA, EOMI
Ears, Nose, Mouth, Throat	HEENT: normal negative, TM's intact, no exudates, nares clear, good/poor dentation
Cardiovascular	RRR, S1 S2, No S3 S4, no gallops, no murmurs
Respiratory	CTAP, no wheezes, no rales, no rhonchi
Gastrointestinal	NABS (normal active bowel sounds), positive bowl sounds, hepatosplenomegaly, liver enlarged, spleen normal
Genitourinary	Pelvic Exam normal, no discharge, kidneys normal
Musculoskeletal	Muscle atrophy, good ROM, muscle tenderness, joint exam, joint stiffness
Skin	No rash, no bruising, exam of venous access site, cyanosis, pale
Neurological	CNS intact, positive deep tendon reflexes
Psychiatric	Patient in agitated space, nor orientated to time and place, nervous, depressed, any description of the patient's judgment, mental status
Hematologic/Lymphatic/Immunologic	No lymphadenopathy

Medical Decision-Making Reference Sheet

Straightforward decision making: 99201, 99202, 99212
One self-limited or minor problem (this would be described as something that would go away on its own such as an insect bite, simple cold} no medical intervention necessary

Low decision making: 99203, 99213
One or two uncomplicated acute illness's (ear infection & cough} prescribing patient short term antibiotics
One or two stable chronic illnesses (stable HTN, COPD, DM}
One chronic illness worsening, uncontrolled hypertension would be an example with a medication change

Moderate decision making: 99204, 99214
One chronic illness worsening with a stable chronic illness where medications are being changed
One new problem with no additional work up, an example would be a patient newly diagnosed with Depression in which a medicine is prescribed.

High decision making: 99205, 99215
***** Very rarely will a level 5 be billed in the clinic based off of the medical decision making*****
One new problem with additional work up, an example would be abrupt change in mental status, and send the patient over to the hospital to be admitted.

Coding Based Off of Time

On some occasions it may be necessary to code a visit based off of the time spent with the patient. In this case the acceptable documentation according to CMS is:

- I spent 45 minutes face to face with the patient more than 50% of the time was spent counseling/coordinating care regarding diabetes management.
- I spent 40 minutes face to face with the patient more than 50% of the time spent counseling/coordinating care regarding recent onset of MS.

1995 Documentation Guidelines for Evaluation and Management Services

I. INTRODUCTION

WHAT IS DOCUMENTATION AND WHY IS IT IMPORTANT?

Medical record documentation is required to record pertinent facts, findings, and observations about an individual's health history including past and present illnesses, examinations, tests, treatments, and outcomes. The medical record chronologically documents the care of the patient and is an important element contributing to high quality care. The medical record facilitates:

- the ability of the physician and other healthcare professionals to evaluate and plan the patient's immediate treatment, and to monitor his/her healthcare over time;
- communication and continuity of care among physicians and other healthcare professionals involved in the patient's care;
- accurate and timely claims review and payment;
- appropriate utilization review and quality of care evaluations; and
- collection of data that may be useful for research and education.

An appropriately documented medical record can reduce many of the "hassles" associated with claims processing and may serve as a legal document to verify the care provided, if necessary.

WHAT DO PAYERS WANT AND WHY?

Because payers have a contractual obligation to enrollees, they may require reasonable documentation that services are consistent with the insurance coverage provided. They may request information to validate:

- the site of service;
- the medical necessity and appropriateness of the diagnostic and/or therapeutic services provided; and/or
- that services provided have been accurately reported.

II. GENERAL PRINCIPLES OF MEDICAL RECORD DOCUMENTATION

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

1. The medical record should be complete and legible.
2. The documentation of each patient encounter should include:
    - reason for the encounter and relevant history, physical examination findings, and prior diagnostic test results;
    - assessment, clinical impression, or diagnosis;
    - plan for care; and
    - date and legible identity of the observer.

3. If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.
4. Past and present diagnoses should be accessible to the treating and/or consulting physician.
5. Appropriate health risk factors should be identified.
6. The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented.
7. The CPT and ICD-9-CM codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.

III. DOCUMENTATION OF E/M SERVICES

This publication provides definitions and documentation guidelines for the three key components of E/M services and for visits which consist predominately of counseling or coordination of care. The three key components-history, examination, and medical decision making--appear in the descriptors for office and other outpatient services, hospital observation services, hospital inpatient services, consultations, emergency department services, nursing facility services, domiciliary care services, and home services. While some of the text of CPT has been repeated in this publication, the reader should refer to CPT for the complete descriptors for E/M services and instructions for selecting a level of service. **Documentation guidelines are identified by the symbol• DG.**

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

- history;
- examination;
- medical decision making;
- counseling;
- coordination of care;
- nature of presenting problem; and
- time.

The first three of these components (i.e., history, examination and medical decision making) are the key components in selecting the level of E/M services. An exception to this rule is the case of visits which consist predominantly of counseling or coordination of care; for these services time is the key or controlling factor to qualify for a particular level of E/M service.

For certain groups of patients, the recorded information may vary slightly from that described here. Specifically, the medical records of infants, children, adolescents and pregnant women may have additional or modified information recorded in each history and examination area.

As an example, newborn records may include under history of the present illness (HPI) the details of mother's pregnancy and the infant's status at birth; social history will focus on family structure; family history will focus on congenital anomalies and hereditary disorders in the family. In addition, information on growth and development and/or nutrition will be recorded. Although not specifically defined in these documentation guidelines, these patient group variations on history and examination are appropriate.

A. DOCUMENTATION OF HISTORY

The levels of E/M services are based on four types of history (Problem Focused, Expanded Problem Focused, Detailed, and Comprehensive). Each type of history includes some or all of the following elements:

- Chief complaint (CC);
- History of present illness (HPI);
- Review of systems (ROS); and
- Past, family and/or social history (PFSH).

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

The chart below shows the progression of the elements required for each type of history. To qualify for a given type of history, **all three elements in the table must be met.** (A chief complaint is indicated at all levels.)

History of Present Illness (HPI)	Review of Systems (ROS)	Past, Family, and/or Social History (PFSH)	Type of History
Brief	N/A	N/A	Problem Focused
Brief	Problem Pertinent	N/A	Expanded Problem Focused
Extended	Extended	Pertinent	Detailed
Extended	Complete	Complete	Comprehensive

- *DG: The CC, ROS and PFSH may be listed as separate elements of history, or tliey may be included in the description of the history of the present illness.*
- *DG: A ROS and/or a PFSH obtained during an earlier encounter does not need to be re-recorded if there is evidence that the physician reviewed and updated the previous information. This may occur when a physician updates his/her own record or in an institutional setting or group practice where many physicians use a common record. The review and update may be documented by:*
    - describing any new ROS and/or PFSH information or noting there has been no change in the information; and
    - noting the date and location of the earlier ROS and/or PFSH.
- *DG: The ROS and/or PFSH may be recorded by ancillary staff or on a form completed by the patient. To document that the physician reviewed the information, there must be a notation supplementing or confirming the information recorded by others.*
- *DG: If the physician is unable to obtain a history from the patient or other source, the record should describe the patient's condition or other circumstance which precludes obtaining a history.*

Definitions and specific documentation guidelines for each of the elements of history are listed below.

CHIEF COMPLAINTS

The CC is a concise statement describing the symptom, problem, condition, diagnosis, physician recommended return, or other factor that is the reason for the encounter.

- *DG: The medical record should clearly reflect the chief complaint.*

HISTORY OF PRESENT ILLNESS (HPI)

The HPI is a chronological description of the development of the patient's present illness from the first sign and/or symptom or from the previous encounter to the present. It includes the following elements:

- location;
- quality;
- severity;
- duration;
- timing;
- context;
- modifying factors; and
- associated signs and symptoms.

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

A ***brief*** HPI consists of one to three elements of the HPI.

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

An ***extended*** HPI consists of four or more elements of the HPI.

- *DG: The medical record should describe four or more elements of the present illness (HP/) or associated comorbidities.*

REVIEW OF SYSTEMS

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

For purposes of ROS, the following systems are recognized:

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

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

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

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

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

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

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

PAST, FAMILY, AND/OR SOCIAL HISTORY (PFSH)

The PFSH consists of a review of three areas:

- past history (the patient's past experiences with illnesses, operations, injuries and treatments);
- family history (a review of medical events in the patient's family, including diseases which may be hereditary or place the patient at risk); and
- social history (an age appropriate review of past and current activities).

For the categories of subsequent hospital care, follow-up inpatient consultations and subsequent nursing

facility care, CPT requires only an "interval" history. It is not necessary to record information about the PFSH.

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

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

A ***complete*** PFSH is of a review of two or all three of the PFSH history areas, depending on the category of the E/M service. A review ·of two of the three history areas is sufficient for other services.

- *DG: At least one specific item from two of the three history areas must be documented for a complete PFSH for the following categories of EIM services: office or other outpatient services, established patient; emergency department; subsequent nursing facility care; domiciliary care, established patient; and home care, established patient.*
- DG: At least one specific item from **each** of the three history areas must be documented for a complete PFSH for the following categories of EIM services: office or other outpatient services, new patient; hospital observation services; hospital inpatient services, initial care; consultations; comprehensive nursing facility assessments; domiciliary care, new patient; and homecare, new patient.

B. DOCUMENTATION OF EXAMINATION

The levels of EIM services are based on four types of examination that are defined as follows:

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

For purposes of examination, the following **body areas** are recognized:

- Head, including the face
- Neck
- Chest, including breasts and axillae
- Abdomen
- Genitalia, groin, buttocks
- Back, including spine
- Each extremity

For purposes of examination, the following organ systems are recognized:

- Constitutional (e.g., vital signs, general appearance)
- Eyes
- Ears, nose, mouth, and throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric

- Hematologic/lymphatic/immunologic

The extent of examinations performed and documented is dependent upon clinical judgment and the nature of the presenting problem(s). They range from limited examinations of single body areas to general multi-system or complete single organ system examinations.

- *DG: Specific abnormal and relevant negative findings of the examination of the affected or symptomatic body area(s) or organ system(s) should be documented. A notation of "abnormal" without elaboration is insufficient.*
- *DG: Abnormal or unexpected findings of the examination of the unaffected or asymptomatic body area(s) or organ system(s) should be described.*
- *DG: A brief statement or notation indicating "negative" or "normal" is sufficient to document normal findings related to unaffected area(s) or asymptomatic organ system(s).*
- *DG: The medical record tor a general multi-system examination should include findings about 8 or more of the 12 organ systems.*

C. DOCUMENTATION OF THE COMPLEXITY OF MEDICAL DECISION MAKING

The levels of E/M services recognize four types of medical decision making (straight- forward, low complexity, moderate complexity, and high complexity). Medical decision · making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by:

- the number of possible diagnoses and/or the number of management options that must be considered;
- the amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed; and
- the risk of significant complications, morbidity, and/or mortality, as well as comorbidities associated with the patient's presenting problem(s), the diagnostic procedure(s) and/or the possible management options.

The chart below shows the progression of the elements required for each level of medical decision making. To qualify for a given type of decision making, **two of the three elements in the table must be either met or exceeded.**

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	Low	Low Complexity
Multiple	Moderate	Moderate	Moderate Complexity
Extensive	Extensive	High	high Complexity

Each of the elements of medical decision making is described on the following page.

NUMBER OF DIAGNOSES OR MANAGEMENT OPTIONS

The number of possible diagnoses and/or the number of management options that must be consider13d is based on the number and types of problems addressed during the encounter, the complexity of establishing a diagnosis and the management decisions that are made by the physician.

Generally, decision making with respect to a diagnosed problem is easier than that for an identified but undiagnosed problem. The number and type of diagnostic tests employed may be an indicator of the number of possible diagnoses. Problems which are improving or resolving are less complex than those which are worsening or failing to change as expected. The need to seek advice from others is another indicator of complexity of diagnostic or management problems.

- *OG: For each encounter, an assessment, clinical impression, or diagnosis should be documented. It may be explicitly stated or implied in documented decisions regarding management plans and/or further evaluation.*
    - For a presenting problem with an established diagnosis the record should reflect whether the problem is: a) improved, well controlled, resolving or resolved; or, b) inadequately controlled, worsening, or failing to change as expected.
    - For a presenting problem without an established diagnosis, the assessment or clinical impression may be stated in the form of a differential diagnoses or as "possible," "probable," or "rule out" (RIO) diagnoses.
- *OG: The initiation of, or changes in, treatment should be documented. Treatment includes a wide range of management options including patient instructions, nursing instructions, therapies, and medications.*
- *OG: If referrals are made, consultations requested or advice sought, the record should indicate to whom or where the referral or consultation is made or from whom the advice is requested.*

AMOUNT AND/OR COMPLEXITY OF DATA TO BE REVIEWED

The amount and complexity of data to be reviewed is based on the types of diagnostic testing ordered or reviewed. A decision to obtain and review old medical records and/or obtain history from sources other than the patient increases the amount and complexity of data to be reviewed.

Discussion of contradictory or unexpected test results with the physician who performed or interpreted the test is an indication of the complexity of data being reviewed. On occasion the physician who ordered a test may personally review the image, tracing or specimen to supplement information from the physician who prepared the test report or interpretation; this is another indication of the complexity of data being reviewed.

- *DG: If a diagnostic service (test or procedure) is ordered, planned, scheduled, or performed at the time of the EIM encounter, the type of service, eg, lab or x-ray, should be documented.*
- *DG: The review of lab, radiology and/or other diagnostic tests should be documented. An entry in a progress note such as "WBC elevated" or "chest x- ray unremarkable" is acceptable. Alternatively, the review may be documented by initialing and dating the report containing the test results.*

- *DG: A decision to obtain old records or decision to obtain additional history from the family; caretaker or other source to supplement that obtained from the patient should be documented. ·*
- *DG: Relevant finding from the review of old records, and/or the receipt of additional history from the family, caretaker or other source should be documented. If there is no relevant information beyond that already obtained, that fact should be documented. A notation of "Old records reviewed" or "additional history obtained from family" without elaboration is insufficient.*
- *DG: The results of discussion of laboratory, radiology or other diagnostic tests with the physician who performed or interpreted the study should be documented.*
- *DG: The direct visualization and independent interpretation of an image, tracing, or specimen previously or subsequently interpreted by another physician should be documented.*

RISK OF SIGNIFICANT COMPLICATIONS, MORBIDITY, AND/OR MORTALITY

The risk of significant complications, morbidity, and/or mortality is based on the risks associated with the presenting problem(s), the diagnostic procedure(s), and the possible management options.

- *DG: Comorbidities/underlying diseases or other factors that increase the complexity of medical decision making by increasing the risk of complications, morbidity, and/or mortality should be documented.*
- *DG: If a surgical or invasive diagnostic procedure is ordered, planned, or scheduled at the time of the EIM encounter, the type of procedure eg, laparoscopy, should be documented.*
- *DG: If a surgical or invasive diagnostic procedure is performed at the time of ttie EIM encounter, the specific procedure should be documented.*
- *DG: The referral for or decision to perform a surgical or invasive diagnostic procedure on an urgent basis should be documented or implied.*

The following table may be used to help determine whether the risk of significant complications, morbidity, and/or mortality is minimal, low, moderate, or high. Because the determination of risk is complex and not readily quantifiable, the table includes common clinical examples rather than absolute measures of risk. The assessment of risk of the presenting problem(s) is based on the risk related to the disease process anticipated between the present encounter and the next one. The assessment of risk of selecting diagnostic procedures and management options is based on the risk during and immediately following any procedures or treatment. The highest level of risk in any one category (presenting problem(s), diagnostic procedure(s), or management options) determines the overall risk.

Table of Risk

Level of Risk	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
Minimal	One self-limited or minor problem, eg, cold, insect bite, tinea corporis	Laboratory tests requiring venipuncture, Chest x-rays, EKG/EEG, Urinalysis Ultrasound, eg, echocardiography KOH prep	Rest Gargles Elastic bandages Superficial dressings
Low	Two or more self-limited or minor problems One stable chronic illness, eg, well controlled hypertension, non-insulin dependent diabetes, cataract, BPH Acute uncomplicated illness or injury, eg, cystitis, allergic rhinitis, simple sprain	Physiologic tests not under stress, eg, pulmonary function tests Non-cardiovascular imaging studies with contrast, eg, 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, eg, lump in breast Acute illness with systemic · symptoms, eg, pyelonephritis, pneumonitis, colitis Acute complicated injury, eg, head injury with brief loss of consciousness	Physiologic tests under stress, eg, 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 eg, arteriogram, cardiac catheterization Obtain fluid from body cavity, eg 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 oi chronic illnesses or injuries that pose a threat to life or bodily function, eg, 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, eg, 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 requiring intensive monitoring for toxicity Decision not to resuscitate or to deescalate care because of poor prognosis

D. DOCUMENTATION OF AN ENCOUNTER DOMINATED BY COUNSELING OR COORDINATION OF CARE

In the case where counseling and/or coordination of care dominates (more than 50%) of the physician/patient and/or family encounter (face-to-face time in the office or other outpatient setting or floor/unit time in the hospital or nursing facility), time is considered the key or controlling factor to qualify for a particular level of E/M services.

- *DG: If the physician elects to report the level of service based on counseling and/or coordination of care, the total length of time of the encounter (face-to-face or floor time, as appropriate) should be documented and the record should describe the counseling and/or activities to coordinate care.*

Employed Physicians and Non-physician Providers Coding, Billing, & Documentation Training and Auditing

I. Purpose

SoutheastHEALTH (SEH) is committed to adhering to all federal and state regulations regarding the provision and documentation of provider services and the assignment of the appropriate codes relating to these services. As such, SEH has developed a comprehensive program for training its providers in the appropriate documentation and coding for professional services. This policy describes the orientation and compliance review related to the training programs offered at SEH and provides direction to SEH employed providers, including physicians, physician assistants, nurse practitioners, and others who may bill for their professional services. This policy outlines the providers' responsibility to attend compliance training and further, specifies corrective actions to be imposed for failure to attend required training or for failing to take all reasonable steps to eliminate and prevent billing, documentation, and coding deficiencies.

II. Applicability

This policy applies specifically to all SEH employed providers, including physicians, physician assistants, nurse practitioners, and others who may bill for their professional services within SoutheastHEALTH Medical Group (SEMG) and the Rural Health Clinics of SoutheastHEALTH (RHC). Other SoutheastHEALTH System entities may either adopt this policy or develop a policy that substantially reflects the requirements of this policy.

III. Policy

SEH employs providers across a number of specialties who may generate claims that will be submitted to Medicare, Medicaid, and other third-party payers for professional services rendered. In an effort to ensure that providers' services are appropriately coded and documented, the Physician Coding Auditor (Auditor), in cooperation with Physician Practice Management, will conduct training sessions which address essential components of coding, billing, and medical record documentation including: Documentation Guidelines for Evaluation and Management Coding, Medicare and Medicaid's requirements for billing the services of non-physician providers, and other billing and documentation rules and regulations.

It is essential that billing providers and coders receive training through these programs on an initial and continuing basis and that they incorporate the elements of that training into their coding, billing and documentation practices with the goal of achieving full regulatory compliance.

Requirements regarding the training of professional staff and the applicable corrective actions for non-compliance with training requirements shall-be as follows:

A. Orientation for New Employees

New employees who provide or code billable professional services are required to attend an orientation training session within thirty (30) days of their date of hire. The Auditor will also remind applicable providers and the appropriate office manager and Physician Practice Management of those individuals who have not completed orientation training within thirty (30) days following the provider's date of hire. Repeated refusal to complete the training will result in further disciplinary action ranging from suspension of employment without pay to termination of employment.

B. Continuing Training and Education

Ongoing training will be provided to providers and coders. The Auditor will conduct or coordinate these sessions. The sessions will be scheduled in advance with Physician Practice Management in a manner to facilitate provider schedules. Providers or coders who do not receive a passing score in their individual review must have a face-to-face meeting with the Auditor.

C. Auditing and Monitoring of Records

The Auditor will review each provider or coder's billing on an ongoing basis to ensure the integrity of billing and supporting documentation of each provider. The Auditor will clarify threshold error rates with department/divisional leadership at the commencement of each review. Error rates found in excess of these threshold rates will be discussed with the appropriate level of management as well as the provider. In addition to the provider reviews, the Auditor may periodically review the billing of individual providers whose billing pattern or activity falls outside SEH or other industry "norms" to ensure the integrity of billing and supporting documentation.

Coding or documentation issues caused by system or other deficiencies outside of the control of the provider will not be charged against his/her score. These issues will be discussed with appropriate leadership for resolution.

Audits will be performed on a prospective basis to the extent possible. In the event that a discrepancy is identified between the code a provider generates and the auditor's findings from the review, the code billed to a third party will reflect the code supported in the documentation of the medical record.

Occurrences and Corrective Actions for Noncompliant Providers and Coders

Following is an outline of the required course of action to be implemented upon one or more provider billing audit failures:

1. **First Occurrence:** (Based upon error rates in excess of thresholds incurred during the Auditor's review)
    - Discussion of audit results with the provider and appropriate office manager;
    - Provide re-training to the provider within 30 days to ensure a thorough understanding of compliance issues and deficiencies identified during the review;
    - Written notification of deficiencies noted in the review and the grading criteria utilized are given to the provider, office manager, and Physician Practice Management;
    - Discussion of an agreement upon corrective action necessary to address deficiencies; and,
    - Re-audit of the provider's records on an expedited basis, appropriate to the provider's level of activity. If the provider passes this review, the process ends and the failure of any future routine review would result in a First Occurrence. Failure of the review will result in a Second Occurrence.

2. **Second Occurrence:** (Based upon error rates in excess of thresholds incurred during the re-audit following a First Occurrence)

- A meeting involving the provider, office manager, Physician Practice Management, and the Physician Coding Auditor to discuss the audit results, and to develop a corrective action plan. The auditor will initiate this meeting, using best efforts to schedule this meeting within fifteen (I 5) business days of the notification of a Second Occurrence from the Auditor, but under no circumstances later than twenty (20) business days from the date of notification. The office manager and Physician Practice Management are directly responsible to ensure that this plan is implemented;
- Written notification of deficiencies noted in the review and the grading criteria utilized are given to the provider, office manager, and Physician Practice Management;
- The Corporate Compliance Officer and Designated member of administration are informed of compliance issues associated with the provider's billings; and,
- Re-audit of the provider's records on an expedited basis, appropriate to the provider's level of activity. Failure of this review will result in a Third Occurrence.

3. **Third Occurrence:** (Based upon error rates in excess of thresholds incurred during the re-audit subsequent to a Second Occurrence)
    - The office manager may be required to institute a self-monitoring plan to ensure that documentation and billing compliance requirements are appropriately followed.
    - Provider billings may be placed on hold or prospectively reviewed by a Certified Professional Coder as determined by Physician Practice Management, the Auditor, & the Corporate Compliance Officer.
    - In accordance with the system compliance policies, the office manager, Physician Practice Management, and provider will meet to develop a corrective action plan and determine appropriate further action. The auditor in coordination with the office manager will initiate this meeting, using best efforts to schedule this meeting within fifteen (15) business days of notification of a Third Occurrence from the auditor, but under no circumstances later than twenty (20) business days from the date of notification. The office manager and Physician Practice Management are directly responsible to ensure that this plan is implemented;
    - Written notification of deficiencies noted in the review and the grading criteria utilized are given to the provider, office manager, and Physician Practice Management;
    - The Compliance Officer, designated member of administration, and Audit & Compliance Committee are informed of compliance issues associated with the provider's billings and updates on the status of corrective action plans
    - The Corporate Compliance Officer and Designated member of administration are informed of compliance issues associated with the provider's billings; and,
    - Re-audit of the provider's records on an expedited basis, appropriate to the provider's level of activity. Failure of this review will result in a Third Occurrence.

D. Sanctions and Corrective Action for Billing and Documentation Issues of Higher Severity:

The Corporate Compliance Officer can be notified at any time without regard to the timeline of this policy and may become involved either inside or outside of the routine audit process.

The Compliance Officer may, in his/her discretion, conduct an expanded review as part of his/her investigation. Using the results of the investigation, the Compliance Officer may recommend additional training, direct progression to a third occurrence, and/or other sanctions, including but not limited to, the suspension of employment without pay or, in the most serious circumstances, the termination of the provider's employment for cause in accordance with the system compliance polices.

IV. Procedure

SEH employees or professional staff members with questions concerning the interpretation of this policy or its applicability to a particular circumstance should first consult with their supervisor. If the employee's supervisor is unable to answer the question or provide appropriate guidance or if, because of the circumstances, it would be inappropriate to discuss the matter with the supervisor then the employee or professional staff member

should contact the Compliance Officer for advice. If any SEH employee or professional staff member is aware of any violation of this policy or suspects that a violation of this policy has occurred, the employee or professional staff member must report the activity consistent with the requirements outlined in the Corporate Compliance Program.

Training Materials Acknowledgement Form

Upon starting my employment as a provider with SoutheastHEALTH, I was given a packet of information including the following:

- New Patient & Consultation Documentation Requirements
- Established Patient Documentation Requirements
- History of Present Illness explanation sheet
- Review of systems explanation sheet
- Examination standards explanation sheet
- Laminated Evaluation and Management reference sheet
- Abstraction sheet
- Medical decision-making sheet
- 1995 Evaluation and Management guidelines
- Documentation training and auditing policy

_____ _____

Provider Name Date

I acknowledge receipt of the materials listed above along with a short training session on coding/billing guidelines.

_____ _____

Provider Signature Date

Southeast Missouri Hospital Physicians, LLC E&M Guide

	Type of History	Key	Definition
HISTORY	Problem Focused	PF	CC, Brief history illness (1-3)
	Expanded Problem Focused	E	CC, Brief history present illness, Problem pertinent ROS (1)
	Detailed	D	CC, Ext HPI, Ext ROS (2-9), pert past family, medical, and social history (1)
	Comprehensive	C	CC, Ext HPI (4+), Complete ROS (10+), Complete past family, medical, and social history (3)

	Type of Examination	Key	Definition
EXAMINATION	Problem Focused	PF	Affected body area or organ system (1)
	Expanded Problem Focused	E	+ Other symptomatic/related organ system (2-7)
	Detailed	D	Extended exam of affected bodv area(s) or related organ system(s) (2-7)
	Comprehensive	C	Complete single-system specialty exam or complete multisystem exam (>8)

	Diagnosis/Options	Data	Risk	=Complexity	Key
MEDICAL DECISION MAKING	Min (<1)	Minimal/None (<1)	Min	Strtfwd	S
	Limited (2)	Limited (2)	Low	Low	L
	Multiple (3)	Moderate (3)	Mod	Mod	M
	Extensive (>4)	Extensive (>4)	High	High	H

	E & M Code	History	Exam	Medical Decision Making	Average Time
OFFICE VISIT NEW PATIENT: 3 OF 3 REQUIRED	99201	PF	PF	S	10
	99202	E	E	S	20
	99203	D	D	L	30
	99204	C	C	M	45
	99205	C	C	H	60

	E & M Code	History	Exam	Medical Decision Making	Average Time
OFFICE VISIT ESTABLISHED PATIENT: 2 OF 3 REQUIRED	99211	N/A	N/A	N/A	5
	99212	PF	PF	S	10
	99213	E	E	L	15
	99214	D	D	M	45
	99215	C	C	H	40

	E & M Code	History	Exam	Medical Decision Making	Average Time
OBSERVATION OR ADMIT / DISCHARGE INPATIENT SAME DAY	99234	D/C	D/C	S	N/A
	99235	C	C	M	N/A
	99236	C	C	H	N/A

Southeast Missouri Hospital Physicians, LLC E&M Guide

	Type of History	Key	Definition
HISTORY	Problem Focused	PF	CC, Brief history illness (1-3)
	Expanded Problem Focused	E	CC, Brief history present illness, Problem pertinent ROS (1)
	Detailed	D	CC, Ext HPI, Ext ROS (2-9), pert past family, medical, and social history (1)
	Comprehensive	C	CC, Ext HPI (4+), Complete ROS (10+), Complete past family, medical, and social history (3)

	Type of Examination	Key	Definition
EXAMINATION	Problem Focused	PF	Affected body area or organ system (1)
	Expanded Problem Focused	E	+ Other symptomatic/related organ system (2-7)
	Detailed	D	Extended exam of affected bodv area(s) or related organ system(s) (2-7)
	Comprehensive	C	Complete single-system specialty exam or complete multisystem exam (>8)

	Diagnosis/Options	Data	Risk	=Complexity	Key
MEDICAL DECISION MAKING	Min (<1)	Minimal/None (<1)	Min	Strtfwd	S
	Limited (2)	Limited (2)	Low	Low	L
	Multiple (3)	Moderate (3)	Mod	Mod	M
	Extensive (>4)	Extensive (>4)	High	High	H

	E & M Code	History	Exam	Medical Decision Making	Average Time
INITIAL INPATIENT CARE: 3 OF 3 REQUIRED	99221	C/D	C/D	S or L	30
	99222	C	C	M	50
	99223	C	C	H	70

	E & M Code	History	Exam	Medical Decision Making	Average Time
SUBSEQUENT HOSPITAL CARE: 2 OF 3 REQUIRED	99231 – Stable/Recovering	PF	PF	S or L	15
	99232 – Minor Complications / Inadequate Response to Therapy	E	E	M	25
	99233 – Unstable / Significant Complication / Significant New Problem	D	D	H	35

	E & M Code	History	Exam	Medical Decision Making	Average Time
HOSPITAL DISCHARGE DAY MANAGEMENT	99238	N/A	N/A	N/A	30 MIN OR LESS
	99239	N/A	N/A	N/A	> 30 MIN

	E & M Code	History	Exam	Medical Decision Making	Average Time
HOSPITAL OBSERVATION – INITIAL CARE: 3 OF 3 REQUIRED	99218	D/C	D/C	S/L	N/A
	99219	C	C	M	N/A
	99220	C	C	H	N/A

	E & M Code	History	Exam	Medical Decision Making	Average Time
OBS. CARE – DISCHARGE SERVICES	99217	N/A	N/A	N/A	N/A