Practice Makes Perfect Series: Tips For E/M Documentation & Coding

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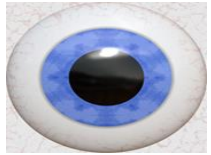
E/M - Evaluation & Management Guidelines

- This is intended as an overview of critical elements that often lead to coding errors.
- All Clinicians are reminded that there are a number of resources available to you for a more thorough review and understanding. A sample of available resources can be found throughout this slide deck

Era Of Enforcement & Data Analysis



- Data analysis is being conducted from a variety of areas, many are aimed at identification of potentially improper billing practices
- It's more important than ever before to ensure proper coding and documentation of all services rendered

Question: Who is looking at your claims data?

Answer: Pretty much every payor

- Diagnosis data reviewed for severity, cost and quality programs, etc.
- CPT data – hunting for opportunity to identify improper code combinations, comparisons to peers, etc.

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Today's Environment

Healthcare Fraud is defined as a crime

Holds providers liable to a standard of you knew or should have known

A provider is ultimately accountable and responsible for correct coding regardless of who you may have delegated the task to.

A thorough understanding of E/M codes, and coding in general is crucial to all clinicians.

Comparisons To Peers

- There are a variety of resources and comparative data sets available to you to better understand how your coding patterns may compare to others
- A frequently referenced source is CMS data. The most recent data available is from 2016 claims, and is available for not only cardiology, but also for electrophysiology and interventional cardiology
- A step you might consider: Request a report of your own personal data and compare yourself to the CMS benchmarks
- CMS data can be found at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareFeeforSvcPartsAB/MedicareUtilizationforPartB.html

Data on the next slide was created for your ease of use based on the CMS information found for cardiology at the link referenced above. Data will change if using electrophysiology or interventional cardiology as your benchmark.

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CMS Cardiology Benchmarks
How Do You Compare?

Benchmark Medicare National Allowed %	CARDIOLOGY
New Patients: 99201-99205	
99201	0%
99202	2%
99203	18%
99204	60%
99205	20%
Established Patients: 99211-99215	
99211	6%
99212	2%
99213	28%
99214	58%
99215	6%

Hospital New Patients: 99221-99223	CARDIOLOGY
99221	7%
99222	40%
99223	53%
Subsequent Hospital Care: 99231-99233	
99231	8%
99232	64%
99233	28%

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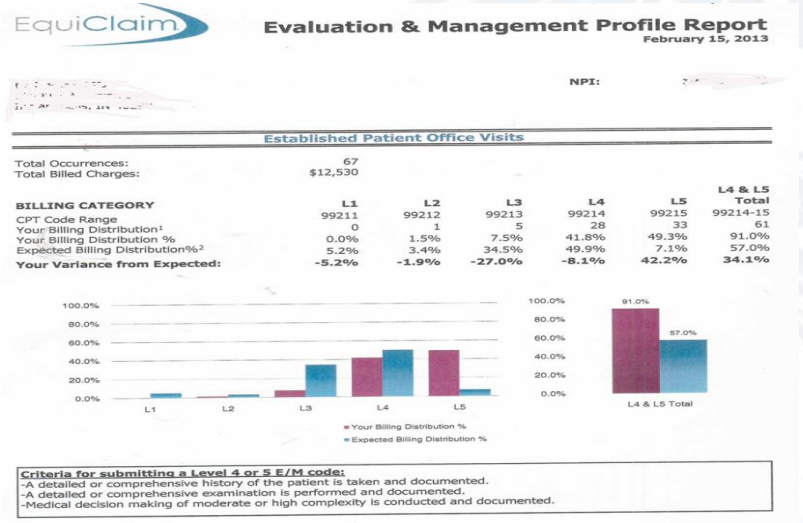
Reviewing Coding Data Is An Activity By No Means Limited to Government Payors

Don't forget:

The E/M Guidelines pertain to all payors. Medicare does publish a variety of information as pertains to documentation expectations, guidelines, and their audit criteria.

TIP: Know what your MAC has made available for you on E/M Guidelines and Education

Sample comparison report from a commercial payor



EquiClaim

Evaluation & Management Profile Report
February 15, 2013

NPI:

Established Patient Office Visits

Total Occurrences: 67
Total Billed Charges: $12,530

BILLING CATEGORY	L1	L2	L3	L4	L5	L4 & L5 Total
CPT Code Range	99211	99212	99213	99214	99215	99214-15
Your Billing Distribution[1]	0	1	5	28	33	61
Your Billing Distribution %	0.0%	1.5%	7.5%	41.8%	49.3%	91.0%
Expected Billing Distribution%[2]	5.2%	3.4%	34.5%	49.9%	7.1%	57.0%
Your Variance from Expected:	**-5.2%**	**-1.9%**	**-27.0%**	**-8.1%**	**42.2%**	**34.1%**

Criteria for submitting a Level 4 or 5 E/M code:
-A detailed or comprehensive history of the patient is taken and documented.
-A detailed or comprehensive examination is performed and documented.
-Medical decision making of moderate or high complexity is conducted and documented.

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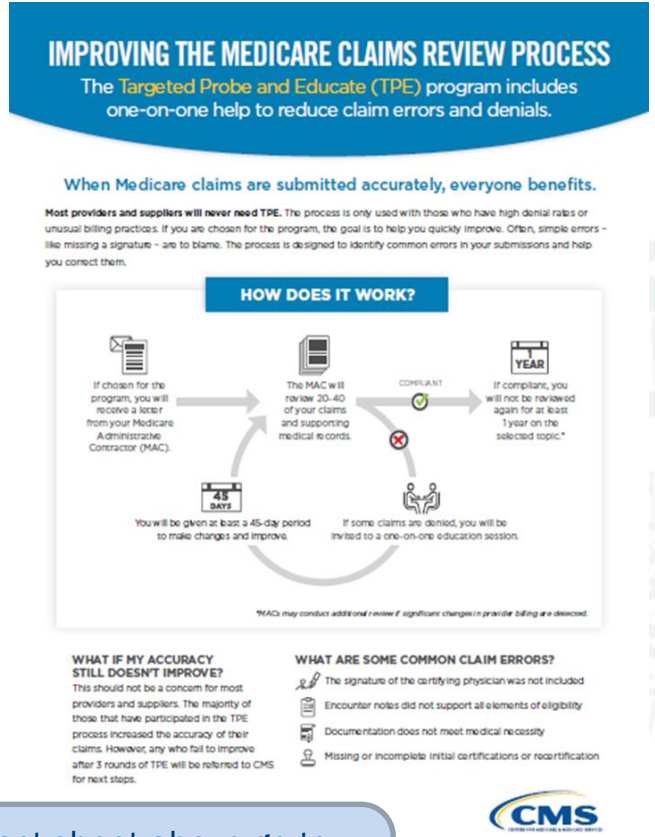
TPE – Targeted Probe and Educate

This is one of the newer programs from CMS designed to provide you with one on one feedback if needed to improve claims submission.

- The TPE review process includes three rounds of a prepayment probe review with education.
- You may be released from further review after any round if your documentation shows the required improvement.
- If there are continued high errors after three rounds, then you could be referred to CMS for additional action, which may include 100% prepay review, extrapolation of results, referral to a Recovery Auditor, or other actions.



IMPROVING THE MEDICARE CLAIMS REVIEW PROCESS

The Targeted Probe and Educate (TPE) program includes one-on-one help to reduce claim errors and denials.

When Medicare claims are submitted accurately, everyone benefits.

Most providers and suppliers will never need TPE. The process is only used with those who have high denial rates or unusual billing practices. If you are chosen for the program, the goal is to help you quickly improve. Often, simple errors – like missing a signature – are to blame. The process is designed to identify common errors in your submissions and help you correct them.

HOW DOES IT WORK?

If chosen for the program, you will receive a letter from your Medicare Administrative Contractor (MAC).

The MAC will review 20-40 of your claims and supporting medical records.

COMPLIANT

If compliant, you will not be reviewed again for at least 1 year on the selected topic.*

45 DAYS

You will be given at least a 45-day period to make changes and improve.

If some claims are denied, you will be invited to a one-on-one education session.

*MACs may conduct additional review if significant changes in provider billing are detected.

WHAT IF MY ACCURACY STILL DOESN'T IMPROVE?

This should not be a concern for most providers and suppliers. The majority of those that have participated in the TPE process increased the accuracy of their claims. However, any who fail to improve after 3 rounds of TPE will be referred to CMS for next steps.

WHAT ARE SOME COMMON CLAIM ERRORS?

- The signature of the certifying physician was not included
- Encounter notes did not support all elements of eligibility
- Documentation does not meet medical necessity
- Missing or incomplete initial certifications or recertification

CMS

For More information as well as the sample fact sheet above go to:
https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Targeted-Probe-and-EducateTPE.html

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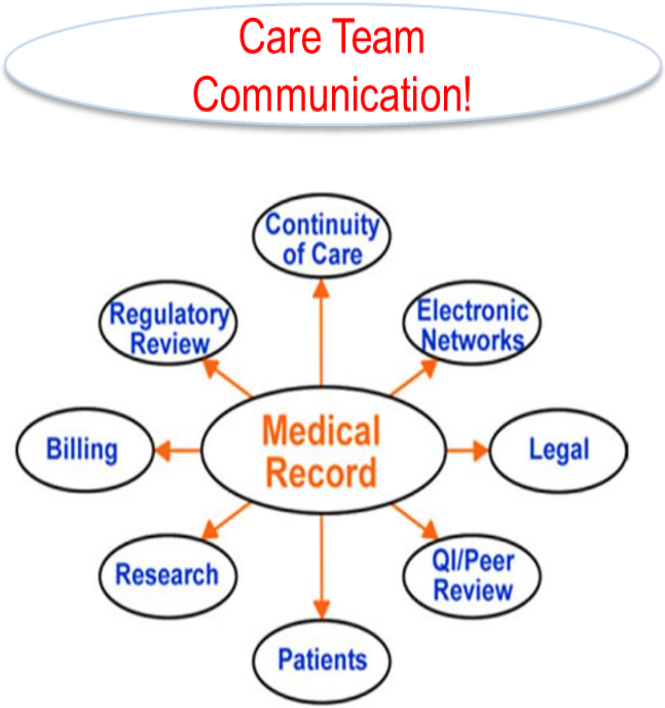
Good Documentation is Essential For Numerous Reasons



As We Get Started…

- None of the E/M guidelines were designed to encourage recording unnecessary information to meet documentation requirements of a higher level service when the nature of the presenting problem related to the visit dictates a lower level service to be medically appropriate
- The level of service should be chosen based on the clinical circumstances of the encounter – and the documentation must support services billed

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General Documentation Tips

In addition to the components of an E/M service, there are several principles of medical documentation that must be considered:

- The medical record should be complete and legible
- The documentation for each patient encounter should include:
  - Reason for the encounter and relevant history, physical examination findings and prior diagnostic test results
  - Assessment, clinical impression or diagnosis
  - Plan for care
  - Date and legible identity of the observer
- If not documented, the rationale for ordering diagnostic and other ancillary services should be able to be inferred easily
- Past and present diagnoses should be accessible to the treating and/or consulting physician
- Appropriate health risk factors should be identified
- The patient's progress, response to treatment, changes in treatment and revision of diagnosis should be documented
- The CPT and ICD-10-CM codes reported on the claim form or billing statement should be supported by the documentation in the medical record

Source: ACC Practice Management/Documentation

A Word On Medical Necessity

Remember that documentation of your E/M service not only supports the medical necessity of that visit – but often also supports the need for diagnostic and therapeutic services ordered or performed as a result of the encounter.

•Medicare Carrier's Manual section 15501A

"…Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. **It would not be medically necessary or appropriate to bill a higher service when a lower level of service is warranted.** The volume of documentation should not be the primary influence upon which a specific level of service is billed…."

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Sample E/M Omissions

- Billing a new patient for the first time a patient is seen in the office following a hospital encounter
- Less than 10 systems in a ROS when a comprehensive history is required
- Missing a family or social history when a comprehensive history is required
- Conflicting information between the HPI and ROS with an EHR
- Having less than the required number of exam elements for a hospital follow-up visit
- Billing for high medical decision making when it is closer to a moderate level

This is obviously not an all inclusive list, however these are the ones that will be focused on in this session as they are some of the most frequently seen

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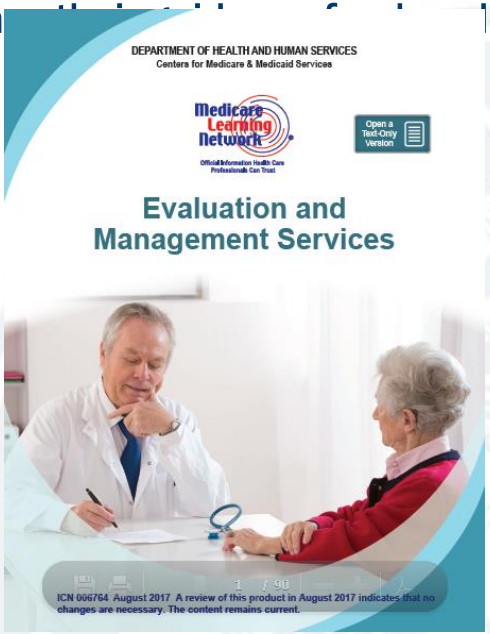
E/M Guidelines

1995 or 1997 Guidelines

- Today both the 1995 and 1997 guidelines are in effect. An auditor is to apply whichever of the guidelines are in the best interest of the Provider
- 97 Guidelines are more thorough and specific in the requirements for documentation of the examination elements.
- You can find the full guidance in the Evaluation and Management section of the AMA's CPT book (Ask your coder, they will happily show you).

CMS publish oad



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Key Terms

Regardless of the code “category” or “setting” type there are reoccurring terms

- **Problem Focused** – History and Exam
- **Expanded Problem Focused** – History and Exam
- **Detailed** – History and Exam
- **Comprehensive** – History and Exam
- **Within Medical Decision Making:** Straight Forward, Low, Moderate and High

Understanding these 12 definitions (and a few more guidelines) is essential to appropriate documentation and coding

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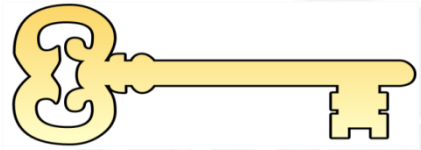
3 Key Elements

E/M services consists primarily of 3 key elements:

- History
- Examination
- Medical Decision Making



- There are also additional guidelines of severity and time
- Under specific circumstances time can become a controlling factor in the selection of an E/M service level

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New or Established Patient?

- **New Patient** – An individual who has not received any professional service from the provider or another provider of the **same specialty** who belongs to the **same group practice** within the previous 3 years
- **Established pt** - one who has received a professional service within the past 3 years

•The guidelines make no distinction between you and your partners of the same specialty. This is also true if you agree to "take call" for someone outside of your group – you treat the patient as the same status as the person you are covering for would have. Here too – you are the "same person".

•Also keep in mind if the patient has not been seen in greater than 3 years, (by same group, same speciality) then returns to you they would qualify as a new patient again.

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CAUTION: New Versus Established Patients

- Pay particular attention when you see the patient in the office for the first time
- If a member of your group, of the same specialty saw them in the hospital setting, observation, emergency room, etc. – then this was a ***professional service with a provider of the same specialty*** so even if it is the first time the patient presents to your office – this is an established patient visit.

- *If you are selecting your level of service using the same thought process regardless of new or established patient status – you might be over-coding*
- The guidelines are different for the various levels of service, depending on the category (new or established) that you are billing.

Example:

99214 - A level 4 ***established*** patient requires a **detailed history and exam.**

99204 - A level 4 ***new*** patient, or ***consult*** requires a **comprehensive history and exam**.

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2 Versus 3 Key Elements

- **Established patient visits and hospital follow-up for example** - bill at level where you meet **2 of the 3 key elements**
- **New patients – Consults – Hospital Admissions** for example, require you to bill at level where **3 out of 3 key** elements are met

- **Impact** – If you have a Comprehensive exam and High medical decision making – but your ROS is less than comprehensive making your history detailed , you can only bill the level 1 Initial visit.

  That very complex patient you might have spent 3 hours on in initial in-patinet care services will now only support the lowest level initial visit code (99221) because you must meet all 3 Key Elements and you only had 2.

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History Elements – CC & HPI

- **Chief Complaint** - –Required for Every E/M Encounter
- **History of Present Illness (HPI)** – MUST be performed and recorded by provider: Expected to include such elements as: –Location, Duration, Quality, Severity, Timing, Context, Modifying Factor(s), Associated Sign(s) or Symptom(s)
- –Brief: 1-3 descriptors (used for problem focused and expanded PF history)
- –Extended: 4 or more descriptors (used for detailed and comprehensive history)
- –1997 guidelines: status of 3 chronic conditions

- All visits require some level of HPI – and this can only be recorded by the provider
- Even the highest levels of E/M services (comprehensive hx) only require 4 HPI elements. I.e. The pt c/o of severe, substernal, nonradiating CP X 4 days not relieved by rest
- Negative responses as well as positive responses are considered and counted
- *The medical necessity of an E/M encounter is often best visualized when viewed through the window of the characteristics captured in HPI elements.*

- Do not limit the CC to "follow up" without elaborating and identifying the problem(s) that are being followed

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Review Of Systems

Constitutional
Eyes
Ears, Nose, Mouth, Throat
Cardiovascular
Respiratory
Gastrointestinal
Genitourinary
Musculoskeletal
Integumentary
Neurological
Psychiatric
Endocrine
Hematologic/lymphatic
Allergic/Immunologic

CAUTION: While acceptable to say ROS negative except as above in HPI – this particular style does have a tendency to be over-coded when a comprehensive hx is needed in my experience. Rarely are there 10 systems in the HPI referenced.

- Only 1 area needed for an expanded history (example: level 3 est pt in the office
- Any 2-9 systems for a detailed history (level 4 est pt in the office
- Comprehensive ROS requires 10 systems

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Comments On Comprehensive ROS

- Inquires about the system directly related to the problem plus all additional systems
- 10 organ systems must be reviewed – more typical for many providers seems to be 7 or 8 systems
- Positives and pertinent negatives must be individually documented
- A notation that all other systems are negative is permissible – as well as unable to obtain (note why it can not be obtained, pt on vent, sedated, etc.)

- Stop what you are doing and check yourself – Review the list of available systems and count the ones you typically address/mention as you dictate. Do you have 10?

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Additional Comments On ROS From Various CMS MACs

- Stating “all others negative” or a similar statement will not always give you credit for having documented the patient’s pertinent negatives and may not meet requirements for a comprehensive history as the number of systems reviewed is unclear
- Guidelines require that all positive responses as well as all pertinent negatives be individually documented.
- Do not note the system(s) related to the presenting problem as “negative” or “normal” – this comment without any further information should be limited to systems unrelated to the presenting problem
- Do not count physical observations as ROS (count them as physical examination).
- It is acceptable to reference a patient completed ROS, it is anticipated that there will be additional comments by the provider and at a minimum an initial and date by the provider to show their review

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Past, Family, & Social History

- You need at least one comment from the area (past, family and social) for it to count

Past	Family	Social
❑Prior major illness and injuries ❑Prior hospitalizations ❑Current medications ❑Prior operations ❑Allergies	❑Health status or cause of death of parents, siblings and children ❑Specific diseases related to problems identified in the chief complaint or history of present illness and system review ❑Diseases of family members which may be hereditary or place the patient at risk	An age appropriate review of: ❑Marital status and/or living arrangements ❑Occupational history ❑Other relevant social factors ❑Current employment ❑Use of drugs, alcohol, tobacco

Past, Family, and Social History

- Not required until you bill for a detailed history. I.e. detailed est pt level 4, or level 3 consult
- Even with a detailed hx only 1 of the areas needs to be covered
- For Comprehensive history – 1 from each category

Hint – Do risk factors when billing a comprehensive history

A common error here is missing the family or social history on an acute presentation

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History - Putting It All Together

History	PF	Exp	Det	Comp
HPI Location, severity, timing, mod factors, quality, duration, context, Associated signs and symptoms	1-3	1-3	4+	4+
Ros – constitutional, heme, eyes, enmt, resp, cardio, GI, GU, musc, integ, psych, all/imm, endo, neuro	N/A	1	2-9	10
Past history Family history Social history	N/A	N/A	1	2-est 3-new/cx

History - Miscellaneous

- ROS and PFSH obtained on an earlier encounter does not need to be rerecorded if there is evidence that the physician reviewed and updated the previous information

- This can be by describing any new information or noting there has been no change

- Must note the specific date and location of the earlier ROS and PFSH to be given credit in the event of an audit

- *Sample MAC Comment: The provider may use an ROS or PFSH from a previous encounter. The provider must notate the date of the earlier ROS or PFSH and review all elements of the previous encounter notating any changes or elements not reviewed.*

Electronic Record/Form Caution

- Make sure all areas are updated for EACH patient encounter
- Templates are acceptable – but must be accurate for the day's encounter
- Conflicting information between the CC/HPI and or ROS can lead to the entire history being considered invalid by an auditor
- Staff may start the ROS – but it can change when speaking to the provider – the provider is responsible for the ultimate accuracy

Not ensuring uniqueness in each encounter and making sure it accurately describes the specifics of **that visit** can lead to a perception of a "cloned" note.

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Cloning – Copy/ Paste Inaccurate Info?

- Maintain the integrity of your patient encounter – be sure to update for accuracy on each patient encounter
- Per the Centers for Medicare & Medicaid Services (CMS), “Documentation is considered cloned when each entry in the medical record for a beneficiary is worded exactly like or similar to the previous entries”

Per the OIG:

- Copy-pasting, also known as cloning, allows users to select information from one source and replicate it in another location. When doctors, nurses, or other clinicians copy-paste information but fail to update it or ensure accuracy, inaccurate information may enter the patient’s medical record and inappropriate charges may be billed to patients and third-party health care payers. Furthermore, inappropriate copy-pasting could facilitate attempts to inflate claims and duplicate or create fraudulent claims.
- Overdocumentation 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 can produce information suggesting the practitioner preformed more comprehensive services than were actually rendered

Physical Exam

- Most common problem area is typically in a hospital follow-up level three visit (99233) where a “detailed” exam is required
- To be given “credit” for a given system it is best to have at least 2-3 comments – better yet 4
- 8 systems are required for a comprehensive exam
- Consider making at least two comments on five systems your minimum – especially on hospital f/u visits
- 95 guidelines - Comprehensive requires a minimum of 8 systems
- 97 guidelines- defines a “general” comprehensive exam as well as many specialty based exams

Examination – Body Areas & Systems

Body Areas

- ❑ Head
- ❑ Neck
- ❑ Chest, including breasts and axilla
- ❑ Abdomen
- ❑ Genitalia, groin, buttocks
- ❑ Back, including spine
- ❑ Each extremity

Organ Systems

- ❑ Constitutional (3 vital signs)
- ❑ Eyes
- ❑ Ears, nose, throat
- ❑ Respiratory
- ❑ Genitourinary
- ❑ Skin
- ❑ Psychiatric
- ❑ Cardiovascular
- ❑ Gastrointestinal
- ❑ Musculoskeletal
- ❑ Neurologic
- ❑ Hematologic

Lymphatic/Immunologic

Counting Exam Elements (95)

Problem focused – 1 (est pt level 2)

Expanded – 2- 7

Detailed – Consider the “4 x 4” method – 4 systems with minimum of 4 comments. This is commonly used with MAC auditors. Know your MAC’s stance.

Comprehensive – 8 plus

Expanded vs Detailed Exam

- One of the differences expected to distinguish an “expanded” exam from a “detailed” exam is the detail in which the examined systems are described. It is anticipated that there will be more extended comments on the impacted area or system.
- *Sample MAC Comment - It is anticipated that the use of “normal”, “negative” or “WNL” notations will be limited to describing unaffected or asymptomatic organ systems. “A notation of abnormal without elaboration is insufficient”.*

Counting Exam Elements (97)

- Using the 97 guidelines requires more detail in the exam in order to support the detailed and comprehensive categories in particular
- Problem focused – 1-5 elements
- Expanded – 6 – 11 elements
- Detailed – 12 elements
- For these the elements can come from a shaded or unshaded box

Exam – Putting It All Together

Limited to affected body area or organ system (one body area or system related to problem)	**PROBLEM FOCUSED EXAM**
Affected body area or organ system and other symptomatic or related organ system(s) (additional systems up to total of 7)	**EXPANDED PROBLEM FOCUSED EXAM**
Extended exam of affected area(s) and other symptomatic or related organ system(s) (additional systems up to total of 7 or more depth than above)	**DETAILED EXAM**
General multi-system exam (8 or more systems) or complete exam of a single organ system (complete single exam not defined in these instructions)	**COMPREHENSIVE EXAM**

EXAM					
Body areas: ❑ Head, including face ❑ Chest, including breasts and axillae ❑ Abdomen ❑ Neck ❑ Back, including spine ❑ Genitalia, groin, buttocks ❑ Each extremity	❑ 1 body area or system	❑ Up to 7 systems	❑ Up to 7 systems	❑ 8 or more systems
Organ systems: ❑ Constitutional (e.g., vitals, gen app) ❑ Eyes ❑ Ears,nose, mouth, throat ❑ Cardiovascular ❑ Resp ❑ GI ❑ GU ❑ Musculo ❑ Skin ❑ Neuro ❑ Psych ❑ Hem/lymph/imm				
	PROBLEM FOCUSED	**EXP.PROB. FOCUSED**	**DETAILED**	**COMPRE-HENSIVE**

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Medical Decision Making

To qualify for a level of MDM, you need to meet 2 of the 3 elements:

1. Diagnosis and management options
2. The amount or complexity of data to review
3. Risk

This can be one of the more difficult areas to “score” on an audit. The MDM is referring to the complexity of establishing a diagnosis and or selecting management options.

Diagnosis and Treatment Options

- A new problem is assumed more complex than an established problem
- A problem requiring add'l work-up is assumed more complex than one without questions
- A established problem – but getting worse is more complex than one that is stable
- Only 2 self-limited or minor problems can be considered

•A score of "4" is the max

Number of Diagnoses or Treatment Options					
A	B	X	C	=	D
Self-limited or minor (stable, improved or worsening)	*Max = 2*		1		
Est. problem (to examiner); stable, improved			1		
Est. problem (to examiner); worsening			2		
New problem (to examiner); no additional workup planned	*Max = 1*		3		
New prob. (to examiner); add. workup planned			4		
			TOTAL		

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The Data Reviewed

- Attempts to assign a value to the various types of data reviewed
- Labs, X-rays, EKG, old records, etc.
- Credit for discussion with performing MD
- Credit for personal review of image versus review of report – i.e. EKG interp
- There is no credit for multiples of the same type – i.e. review 5 labs – get 1 point

•A score of “4” is the max

Data to be reviewed	Point
Review and/or order lab tests	1
Review and/or order radiology	1
Review and /or order medicine section	1
Discussion of results with performing MD	1
Review and summary of old records, and/or obtaining hx from other than pt, and /or discuss case with health care professional	2
Independent visualization of image, tracing or specimen itself	2
Total	

Table Of Risk

Provided as a guide as this is highly subjective

Includes examples in 3 categories:

1) Presenting problem (s)
2) Diagnostic Procedure (s) Ordered
3) Management Options Selected

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., echo • 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 or 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 • Clincal 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 cath • 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 may 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 or 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 de-escalate care because of poor prognosis

Comments on Table of Risk

- Pay particular attention to the presenting problem
- A significant number of cardiology patients will be at the moderate level

- Note the management options where you will see prescription drug management also at the moderate level.
  - You will be given credit here when you add or change a medication dose
  - You can also be given credit for making the determination NOT t o make a change, i.e. pt stable on current ACE/ARB regime

- Pay attention to the diagnostic procedure(s) ordered
- Note tests under stress is moderate
- Note a cardiac catheterization without risk factors is moderate – but with risk factors is high
- Note EP studies, major surgeries is high

Take the time to really study and get comfortable with this table as combined with mentioning multiple conditions and the data you reviewed, it is critical to picking your level of service.

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Comment on Diagnosis Coding

- We can't end the session today without a brief reminder on the importance of diagnosis coding.
- As we prepare to shift from a reimbursement culture of volume to value the importance of representing the patient's condition to the greatest level of specificity you know is more important than ever before. This includes coding the comorbidities that factor into your decision making as well.
- For more information there are a variety of presentations on RAF/HCC coding available from the CV Summit

THANK-YOU FOR YOUR TIME AND PARTICIPATION!

Practice Makes Perfect Series

Linda Gates-Striby

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