Vail Valley Medical Center – Compliance Department

Compliance Officer: Vicki Dwyer, RN, MN, CHC, CPC
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To Make an Anonymous Report:
Compliance Hotline: 970-569-7550
compliance@vvmc.com

Professional Background:

- **Education:** Diploma in Nursing – St. Francis School of Nursing, Wichita, KS
  Bachelor of Science in Nursing – WSU, Wichita, KS
  Masters in Nursing – WSU, Wichita, KS
  Graduate Certificate in Healthcare Corporate Compliance – George Washington University, Washington, D.C.

- **Nursing:** Registered Nurse – 30+ years (MICU/CCU, Pediatrics, TJC, QI, Education, Risk Management, Staffing,)
  Advance Practice Registered Nurse – Clinical Nurse Specialist – 10+ years (KS)
  Adjunct Faculty, Wichita State University School of Nursing – 20+ years

- **Compliance:** 15+ years as Chief Compliance Officer, Wichita, KS
  Development & Implementation of Comprehensive Compliance Programs
  Government Investigations / Integrity Agreements
  Documentation & Billing Evaluation & Management Services
  National Speaker on Compliance

- **Certifications:** Certified in Healthcare Compliance (CHC)
  Certified Professional Coder (CPC)

Services Available to Physicians:

- **Education and Training** Documentation of Evaluation and Management Services
  Anti-kickback Statutes & Stark Law
  False Claims Act
  Patient Inducement Regulations
  EMTALA
  HIPAA & HITECH

- **Audits & Monitoring** Evaluation & Management Services, Preventive Services
  Rental Leases & Service Agreements
  Medical Necessity for Testing
  Compliance Programs

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Fun Facts:

- **Family** Children – Jim in Wichita, Amy in Denver
  Grandsons – Keegan in Wichita (2 yrs.), Grayden in Denver (3 yrs.)
  Parents – both living in Wichita, KS
  2 brothers – both in Texas
- **Pets** 3 cats (Tequila, Trouble & Velvet)
- **Favorite Things** Playing with grandsons, Reading by the fire, a cup of tea and my cats
- **Favorite Colors** Pink and Blue
- **Favorite Food** Prime Rib and Lobster
- **Favorite Movie** Sweet Home Alabama

Vail Valley Medical Center

Departmental Compliance Audit for _____ Person Completing Audit: _____

Date: _____

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Patient MRN & DOS *E&M documentation compliant and supports level of service billed?*	MRN / DOS	MRN / DOS	MRN / DOS	MRN / DOS	MRN / DOS	MRN / DOS	MRN / DOS	MRN / DOS	MRN / DOS	MRN / DOS	MRN / DOS	MRN / DOS	MRN / DOS	MRN / DOS	MRN / DOS
Level of History															
Level of HPI															
Level of PFSH															
Level of ROS															
Level of Exam															
Level of MDM															
Diagnoses															
Data Collection															
Risk															
Level of Service Billed															
Level of Service Supported by Documentation															
LOS Billed Correctly:															

S – Supported by Documentation UD – Under Documented UB – Under Billed NB – Not Billable

Departmental Compliance Audit for _____ **Date:** _____

Comments:

Patient #1 – MRN _____ / DOS _____ A 992____ was billed
Patient #2 – MRN _____ / DOS _____ A 992____ was billed
Patient #3 – MRN _____ / DOS _____ A 992____ was billed
Patient #4 – MRN _____ / DOS _____ A 992____ was billed
Patient #5 – MRN _____ / DOS _____ A 992____ was billed
Patient #6 – MRN _____ / DOS _____ A 992____ was billed
Patient #7 – MRN _____ / DOS _____ A 992____ was billed
Patient #8 – MRN _____ / DOS _____ A 992____ was billed

Departmental Compliance Audit for _____ **Date:** _____

Patient #9 – MRN _____ / DOS _____ A 992____ was billed
Patient #10 – MRN _____ / DOS _____ A 992____ was billed
Patient #11 – MRN _____ / DOS _____ A 992____ was billed
Patient #12 – MRN _____ / DOS _____ A 992____ was billed
Patient #13 – MRN _____ / DOS _____ A 992____ was billed
Patient #14 – MRN _____ / DOS _____ A 992____ was billed
Patient #15 – MRN _____ / DOS _____ A 992____ was billed
Other Comments: Encounters reviewed: 15 Documentation supports a higher level of service: _____ (_____%) Documentation supports a lower level of service: _____ (_____%) Documentation supports the level billed: _____ (_____%)

Departmental Compliance Audit for _____ Date: _____

Corrective Action:
Follow-Up Plan:

Vail Valley Medical Center
Coding and Documentation Compliance Review

Coding and Documentation Audit

Review Date: February 2013

Provider: Good Doctor, MD

Reviewer: Vicki Dwyer, CPC

Number of Records Reviewed: 15

Type of Review: ☐ **Quarterly Coding and Documentation Compliance Review**

☑ **Annual Coding and Documentation Compliance Review**

☐ **Interval Coding and Documentation Compliance Review**

Results

Documentation	Number	Percent
supports level of service billed	9	60%
supports a lower level of service	3	20%
supports a higher level of service	3	20%
Incorrect category of E&M Service billed	0	0%
Not a billable under this provider	0	0%

Documentation and Coding Issues

Discrepancies: On three encounters, documentation supported a 99203 when a 99204 was billed. A detailed exam was documented and dropped the level from a 99204 to a 99203. A Comprehensive exam of at least 8 systems is required for a 99204.

On one encounter, documentation supported a 99214 when a 99212 was billed. A 99212 only requires a Problem focused history and exam and straightforward medical decision making. On this encounter, a detailed and exam and moderate medical decision making was documented.

On two encounters, documentation supported a 99213 when a 99212 was billed. A 99212 only requires a Problem focused history and exam and straightforward medical decision making. On these encounter, an expanded history and exam and low medical decision making was documented.

Vail Valley Medical Center
Coding and Documentation Compliance Review

History of Present Illness (HPI): Consistently documents at least 4 elements in the HPI. All information in HPI is pertinent to visit and chief complaint.

Review of Systems (ROS): New patient encounters documented a separately identifiable ROS. ROS is based on patient's presenting problem. Established patient encounters did not separately document a review of systems. ROS had to be taken from the HPI. Auditors prefer a separately identifiable ROS and could miss the systems reviewed in the HPI, resulting in the level of service being lowered.

Past medical, Family, Social History (PFSH): New patient encounters documented separately identifiable PFSH. It was noted that ROS was dictated between the past medical history and the social/family histories. Established patient encounters did not separately identify PFSH. PFSH was taken from the HPI. Again, auditors prefer a separately identifiable PFSH and could miss it the HPI, resulting in the level of service being lowered. If referring to unchanged PFSH from a previous visit, the date of the previous visit must be documented and some notation on the previous visit should be made that the PFSH was reviewed (initialed and dated).

Examination: Examination was weak in several of the encounters. For a new patient level 4 or 5, a minimum of 8 body or organ systems must be documented. Body systems identified by the 1995 Documentation Guidelines include: Constitutional, Eyes, Respiratory, Gastrointestinal, Genitourinary, Musculoskeletal, Skin, Neurological, Lymphatic and Psychiatric. On two encounters, the level of service billed was supported by the nature of the presenting problem and medical decision making, however the examination only documented 7 body systems. Had 8 systems been documented, these encounters would have qualified for a level 5 due to the high level of medical decision making documented.

Medical Decision Making (Diagnoses, Data, and Risk): There is good documentation in the medical records on the final diagnoses and lab/testing ordered. On established patients, include whether the problems or diagnoses are new, stable, worsening or improving to support the medical decision making.

Four encounters documented that over an hour was spent with the patient and described the content of the counseling provided. Billing based on time requires the following three elements:

1. Total face-to-face time spent with patient
2. Time spent counseling (showing greater than 50%)
3. Content of counseling

Had you documented "Over one hour was spent with the patient with more than 50% spent on counseling as documented above" the service would have been billable at a level 5.

Nature of the Presenting Problem (NOPP): The nature of the presenting problem was at or above the level billed.

Medical Necessity of level of History and Exam: The level of history and examination were supported by the level of medical decision making.

Vail Valley Medical Center
Coding and Documentation Compliance Review

Action Plan and Follow-up

Recommendations:

- Include separately identifiable ROS and PFSH on all patients.
- For patients with moderate to high medical decision making document the examination of at least 8 body systems to support your level of service.
- Billing based on time – CMS requires documentation of the total time spent with the patient, the total time spent counseling (which must be greater than 50%) and the content of the counseling.

Education Provided:

- Vicki Dwyer, Compliance Officer met with Dr. Doctor to review audit results on March 2, 2013.
- Education was provided on documentation of the key elements (History, Examination and Medical Decision Making). The audit form was reviewed with Dr. Doctor and an encounter was used to demonstrate the audit process. Guidelines and helpful hints and a copy of the audit form were provided. I provided my contact information to Dr. Good and instructed her to contact me anytime she had questions regarding level of service.

Follow-Up Audit:

- ❑ Level I Review (___ Encounters Annually)
- ❑ Level II Review (___Encounters Bi-annually)
- ❑ Level III Review (___Encounters Quarterly)
- ❑ Level IV Review (___Encounters Monthly)
- ❑ Other Level of Review: 10 encounters in 6 weeks.
- ❑ Additional Education on Documentation
- ❑ Refer to the Compliance Officer

_____ _____

Provider Signature Reviewer Signature

DISCLAIMER

This report is based on a randomly selected, non-significant sample of charges. The Vail Valley Medical Center Compliance and Coding Departments strive to maintain quality and accurate information regarding Medicare's Policy and Payment Rules. However, rulings regarding procedures and payments change regularly. The opinions/recommendations expressed within this document are not intended as a guarantee that you are in compliance with Medicare's rules and Regulations.

Vail Valley Medical Center
Coding and Documentation Compliance Review

Coding and Documentation Audit

Review Date:

Provider:

Reviewer:

Number of Records Reviewed:

Type of Review: ❑ **Quarterly Coding and Documentation Compliance Review**

❑ **Annual Coding and Documentation Compliance Review**

❑ **Interval Coding and Documentation Compliance Review**

Results

Documentation	Number	Percent	$$ Impact
supports level of service billed			
does not support level of service billed			
supports a higher level of service			
Incorrect category of E&M Service billed			
Not billable under this provider			

Documentation and Coding Issues

Discrepancies:

History of Present Illness (HPI):

Review of Systems (ROS):

Past medical, Family, Social History (PFSH):

Examination:

Medical Decision Making (Diagnoses, Data, and Risk):

Nature of the Presenting Problem (NOPP):

Medical Necessity of level of History and Exam:

Vail Valley Medical Center
Coding and Documentation Compliance Review

Action Plan and Follow-up

Recommendations:

Education Provided:

- _____ met with _____ to review audit results on _____,
- Education was provided on _____.

Follow-Up Audit:

- ❑ Level I Review (___ Encounters Annually)
- ❑ Level II Review (___Encounters Bi-annually)
- ❑ Level III Review (___Encounters Quarterly)
- ❑ Level IV Review (___Encounters Monthly)
- ❑ Other Level of Review:
- ❑ Additional Education on Documentation
- ❑ Refer to the Compliance Officer

_____ Provider Signature

_____ Reviewer Signature

DISCLAIMER

This report is based on a randomly selected, non-significant sample of charges. The Vail Valley Medical Center Compliance and Coding Departments strive to maintain quality and accurate information regarding Medicare's Policy and Payment Rules. However, rulings regarding procedures and payments change regularly. The opinions/recommendations expressed within this document are not intended as a guarantee that you are in compliance with Medicare's rules and Regulations.

E/M DOCUMENTATION – MULTI-SPECIALTY OFFICE

Auditor: _____ **Provider:** _____

Department / DOS: MSA / **Pt Name / MR #:** _____

Patient New to Specialty? Yes No **Patient Age:**

History

1.	Chief Complaint (CC) Appropriate?					
2.	History of Present Illness (HPI)	Location	Severity	Timing	Mod. Fact.	❑ Status of 1-2 chronic Conditions
		Quality	Duration	Context	Sx & Symp	❑ Status of 3 chronic conditions
3.	Past, Family, Social History (PFSH)	Past Medical	Family	Social		
4.	Review of Systems (ROS)	Constitutional (wt loss, etc)	Allrg/Immun	GI	Musculoskel	Psych
		Eyes	Resp	GU	Integument (skin/breast)	Hemat/Lymp
		ENMT	CV	Endocrine	Neurologic	All Others Negative

HPI	PFSH	ROS	Level of HX
	n/a	n/a	Problem
Brief (1-3 elements or 1-2 chronic conditions)	n/a	problem (1)	Expanded
	pertinent (1)	extended (2-9)	Detailed
Extended (4 or more elements or 3 chronic conditions)	complete (n–3; e–2)	complete (10)	Compreh

All three elements in table must be met

Examination

Body Areas:

Head, including face	Chest, including breasts & axillae	Abdomen	Neck	Back, including spine	Genitalia, groin, buttocks	Each Extremity

Organ Systems:

1.	Constitutional ★	• VS (3)	• General					
2.	Eyes ★	• Conj / lid	• Pupil	• Disc				
3.	Ears, Nose, Mouth & Throat★	• TM	• Hear	• Orophar	• Dent	• Nasal	• Extrn	
4.	Respiratory★	• Ausc	• Effort	• Percus	• palp			
5.	Cardiovascular★	• Ausc	• Palp	• Edema	• Carotid	• Aorta	• Femoral	• Pedal
6.	Gastrointestinal ★	• Abd	• Hep/Sple	• Hernia	• Rectal	• Guiac		
7.	Genitourinary – Female★	• Extrn	• Blad	• Cervix	• Uterus	• Adnx		
8.	Genitourinary – Male★	• Scrotum	• Penis	• Prostate	• Urethra			
9.	Musculoskeletal ★	• Gait	• Digit					
		Exam of joints, bones & muscles in **at least 1** of the following 6 areas:						
	a. Head and neck	• Inspect	• Palpate	• ROM	• Stability	• Strength	• Tone	
	b. Spine, ribs and pelvis	• Inspect	• Palpate	• ROM	• Stability	• Strength	• Tone	
	c. Upper Extremity RT / LT / Both	• Inspect	• Palpate	• ROM	• Stability	• Strength	• Tone	
	d. Lower Extremity RT / LT / Both	• Inspect	• Palpate	• ROM	• Stability	• Strength	• Tone	
10.	Skin ★	• Inspect	• Palpate					
11.	Neurologic★	• CN	• DTR	• Sensat				
12.	Psychiatric★	• Memory	• Orient	• Judge / Insight		• Mood/Affect		
13.	Lymphatic/Hematologic/Immuno★	• Neck	• Axilla	• Groin	• Other	*1997 – 2 or more lymph*		
TOTALS:		**Number of Body Areas:**		**Number of Organ Systems/Elements:**				

(1995 Guidelines)	(1997 Guidelines) Elements Documented and Performed	Exam
	Multi-System Elements	
1 body area or system	1 – 5 bullets	**Problem**
Up to 7 systems	6 – 11 bullets	**Expan5ded**
Up to 7 systems (4 systems with 4 elements)	**At least two** elements identified by a bullet **from each of six areas/systems**	**Detailed**
8 or more systems	Document **at least two** elements identified by a bullet from **each of nine areas/systems**	**Compreh**

Medical Decision Making

1.	**Number of Problems**	Self-limited /Minor (Stable, Improved, Worsening)		X 1		(2 max)	
	a. Established Problems **(to examiner)**	Stable, Improved		X 1			
		Worsening		X 2			
	b. New Problems **(to examiner)**	No additional workup planned		X 3		(1 max)	
		Additional workup planned		X 4		Total:	

2. Amount of Data (Review/Order)	**1 point each**	**1 point each**	**2 points**	
	• Clinical Lab Tests • X-Ray (7xxxx CPT) • Other Tests (9xxxx CPT)	• Obtain old records &/or obtain history from other than patient • Discuss test results w/performing	• Summation of old records/discuss w/other prov • Independent review	Total:

3. Overall Risk (See Table)	Minimal	Low	Moderate	High	

Table of Risk	Nature of Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
Minimal	• One self-limited or minor problem (cold, insect bite, tinea corporis)	• Laboratory test requiring venipuncture • Chest x-rays, Urinalysis, KOH prep • EKG/EEG, Ultrasound (EKG)	• Rest • Gargles • Elastic or superficial dressings
Low	• 2 or more self-limited or minor problems • 1 stable chronic illness (well controlled hypertension, NIDDM, cataract, BPH) • Acute uncomplicated illness or injury (cystitis, allergic rhinitis, simple sprain)	• Physiologic tests not under stress (PFT) • Non CV imaging studies w/contrast (Barium) • Superficial needle biopsy • Clinical lab tests requiring arterial puncture • Skin biopsy	• Over the counter drugs • Minor surgery with no identified risk factors • Physical therapy • Occupational therapy • IV fluids without additives
Moderate	• 1 or more chronic illnesses w/mild exacerbation • 2 or more stable chronic illnesses • Undiagnosed new problem w/uncertain prognosis • Acute illness w/systemic symptoms (colitis, pyelonephritis, pneumonitis) • Acute complicated injury (head injury brief loss of consciousness)	• Physiologic tests under stress (cardiac stress test, fetal contraction stress test) • Diagnostic endoscopies with no identified risks • Deep needle or incisional biopsy • CV imaging w/contrast, no identified risks (arteriogram, cardiac catheterization) • Obtain fluid from body cavity (lumbar puncture, thoracentesis, culdocentesis)	• Minor surgery with identified risk factors • Elective major surgery – no identified risks • Prescription drug management • Therapeutic nuclear medicine • IV fluids with additives • Closed treatment of fracture or dislocation without manipulation
High	• 1 or more chronic illness with severe exacerbation, progression, or side effects of treatment • Acute or chronic illness or injuries that may pose a threat to life or bodily function (multiple trauma, acute MI, PE, severe respiratory distress, progressive severe RA, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure) • An abrupt change in neurologic status (seizure, TIA, weakness or sensory loss)	• CV imaging w/contrast with identified risk factors • Cardiac electrophysiological tests • Diagnostic endoscopies with identified risk factors • Discography	• Elective major surgery with identified risk factors (open, percutaneous or endoscopic) • 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

The highest level of risk in any one category determines the overall risk

# of Diagnosis or Treatment Options	Amount & Complexity of Data	Highest Risk	Level of DM
Minimal (0-1)	Minimal or low (0-1)	Minimal	**Straightforward**
Limited (2)	Limited (2)	Low	**Low Complexity**
Multiple (3)	Moderate (3)	Moderate	**Moderate Complexity**
Extensive (4 or ↑)	Extensive (4 or ↑)	High	**High Complexity**

Diagnosis (Two of the three elements in table must be either met or exceeded)

Modifier **N/A** **Yes** **No**

❑ **Reported**

❑ **Not Reported**

Comments:

Time Based (Counseling or Coordination of Care)		
Does documentation reveal total face-to-face time with the patient?	**Yes**	**No**
Does documentation describe the content of counseling or coordinating care?	**Yes**	**No**
Does documentation reveal that more than half of the time was counseling or coordinating care?	**Yes**	**No**
If all answers are "yes", select level based on time.		

	Established Patient					**New Patient /** ***Consultation (Commercial Only)***				
	99211	**99212**	**99213**	**99214**	**99215**	**99201 / 41**	**99202 / 42**	**99203 / 43**	**99204 / 44**	**99205 / 45**
HX	n/a	problem	expand	detailed	comprehen	problem	expand	detailed	comprehen	comprehen
EX	n/a	problem (1)	expand (5)	detailed (12)	comprehen	problem	expand	detailed	comprehen	comprehen
MDM	n/a	straightforward	low	mod	high	straight	straight	low	mod	high
Time	5	10	15	25	40	10	20	30	45	60
At least 2 must meet or exceed level requirements						***All three must meet or exceed level requirements***				

Level of Service Selected/Billed: _____

Level of Service Supported: _____

Level of Service:

❑ **Supported by Documentation** ❑ **Under-Billed** ❑ **Under-Documented**

History:

History of Present Illness:

- May include chief complaint (why the patient is there)
- 8 HPI Elements –
  - **Location** – *where* on the body the symptom is occurring.
  - **Quality** – *character* of the symptom, e.g. burning, stabbing, fullness, pressure, tightness, etc.
  - **Severity** – How bad is it? Pain on a scale from 1-10. Can also be described with terms like severe, slight, worst I've ever had, etc.
  - **Duration** – how long the symptom has been present or how long it lasts when the patient has it, e.g. last 2-3 minutes, started 4 months ago, etc.
  - **Timing** – when the pain/symptom occurs, e.g. night, after meals, before meals, after I take medication, after or during exercise, intermittent, etc.
  - **Context** – the *situation* associated with the pain/symptom, e.g. dairy products, big meals, strenuous exercise, walking up stairs, etc.
  - **Modifying factors** – things done to make the symptom worse or better, e.g. eating spicy foods makes heartburn worse, drinking milk relieves heartburn; I have migraines but if I lie down in a quiet room with an ice pack on my head it helps the pain.
  - **Associated signs and symptoms** – describes the symptom and other things that happen when this symptom occurs, e.g. chest pain leads to shortness of breath, headache leads to vision constriction.
- **Extended HPI (Comprehensive History)**
  - 4 elements documented in HPI OR
  - Status of 3 Chronic Conditions

Review of Systems (ROS)

- Inventory of "symptoms" patient is currently having in each of the 14 body systems, e.g. wt. loss, blurred vision, nasal drainage, chest pain, cough, constipation, dysuria, joint pain, rash, dizziness, anxiety, facial hair, bruising, frequent infections, etc.
- Do not use "no history of" or "non-contributory"
- It is not considered "double dipping" to use the system(s) addressed in the HPI for ROS credit.
- **Complete ROS:**
  - 10 or more systems OR pertinent positives and/or negatives of some systems with a statement "all others negative"

Complete Past Medical, Family & Social History (PFSH):

- Need 2 of the 3 areas for established patients & ED
- Need 3 of 3 areas for new patients, initial hospital care, and initial hospital observation
- May use "non-contributory" if the history is not pertinent to the presenting problem.

Key Points:

- Not required to re-record Review of Systems (ROS) and Past Family Social History (PFSH) from a previous encounter. **Must show evidence of physician review and update on the previous encounter, e.g. sign/initial and date.**
- Ancillary staff may record ROS and/or PFSH. **Physician must review and supplement or notate confirmation of info recorded. Again, sign/initial & date**
- Unable to obtain history, physician must indicate why and the attempts made.

Exam:

- **Statement of "Abnormal" is not sufficient.**
  - Must document what is pertinent normal and abnormal findings
- **Exam Levels:**
  - Problem Focused (99212 & 99201) – 1 body area or system
  - Expanded Problem Focused (99213 & 99202) – Up to 7 systems

- Detailed (99214 & 99203) – Up to 7 systems (4X4 rule)
- Comprehensive (99215 7 99204-05) – 8 or more systems

- **Novitas' "4X4" rule**
  - 4 or more items for 4 or more body areas or organ systems = DETAILED exam
  - Examples:
    - Constitutional – BP① Temp② Pulse③ Respirations④
    - Respiratory – Chest clear to auscultation① Normal effort② No rales③ or rhonchi④
    - Cardiovascular – Regular rate① and rhythm② no S1③ or S2④
    - Gastrointestinal – Abdomen soft,① non-tender② Normal bowel sounds③ No hepatosplenomegaly④⑤ (hepatosplenomegaly would count as two items).

Medical Decision Making:

Diagnoses or Treatment Options

- Establish Problems vs. New Problems (**to the Examiner** or Same Specialty in Group)
  - **Additional Work-up** (new problem)
    - Anything that is being done beyond that encounter at that time.
    - E.g. sees patient and sends for further testing.

Amount &/or Complexity of Data Reviewed

- Clinical **labs** – count as 1 point, regardless of number of labs ordered.
- All tests in the **radiology** section of CPT (70000) – count as 1 point, regardless of number of tests ordered.
  - Includes all x-rays, CAT Scans, MRI, Nuclear Medicine Scans, Ultrasound
- All tests in the **medicine** section of CPT (90000) – count as 1 point, regardless of number of tests ordered.
  - Examples: ECG, EEG, EMG, Sleep Tests
- Documented use of **Translator** qualifies for 1 point as "obtain History from someone other than patient"
- **Summarization of old records** qualifies for 2 points in this section.
- **Independent visualization of image, tracing or specimen** qualifies for 2 points. Must document that you reviewed the actual image, tracing and did not just read the report, e.g. I personally reviewed the CT images".

Risk Table

- Includes Presenting Problems, Diagnostic Procedures Ordered, and Management Options Selected
- **Overall Risk** is determined by highest5 level of risk identified in these three areas.
  - Moderate Risk - Diagnostic Endoscopies and Elective Major Surgery with NO risk factors identified
    - High Risk - Diagnostic Endoscopies and Elective Major Surgery with risk factors identified. Document Risk Factors, e.g. "identified risk factors included diabetes, coronary artery disease, airway management"

Moderate Medical Decision Making Examples

- New problem to examiner, requiring additional follow-up of major surgery with no identified risk factors
- New problem to examiner, requiring additional follow-up of endoscopy with no identified risk factors
- **Established Patient (99214)** document either a detailed history and/or examination.
- **New Patient (99204)** document BOTH a comprehensive history and examination.

High Medical Decision Making

- New problem to examiner, requiring additional follow-up of major surgery with identified risk factors
- New problem to examiner, requiring additional follow-up of endoscopy with identified risk factors
- **Established Patient (99215)** document either a comprehensive history and/or examination.
- **New Patient (99205)** document BOTH a comprehensive history and examination.

Time:

- Document total face-to-face time with the patient
- Document more than 50% of the time was spent providing counseling or coordination of care
- Describe the content of the counseling or coordination of care.
- Example: 45 minutes total face to face time spent with patient, more than 50% (or 25 minutes) spent counseling.