



Evaluation & Management Services – The Grey Areas

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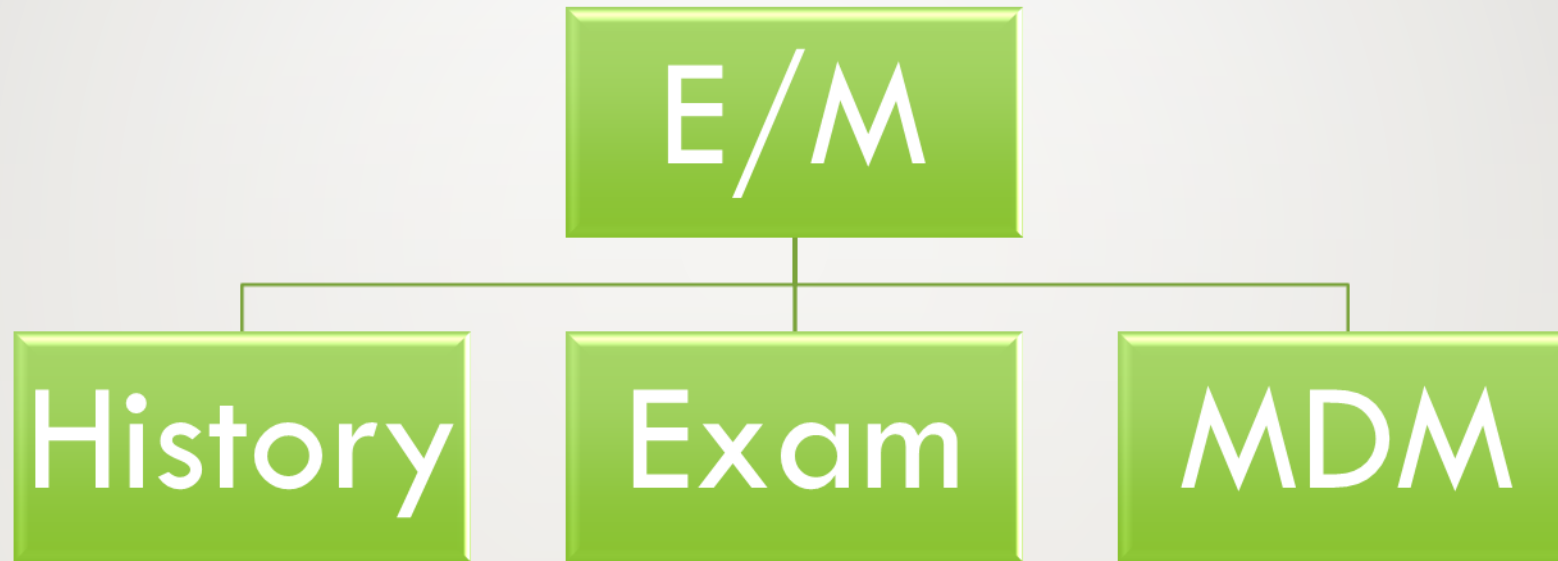
MISSOURI MGMA SPRING CONFERENCE, MAY 6-8, 2018



Session Overview

- **E/M Charge Capture Review**
- **Audit Tools & Practicum**
- **Gray Areas**
 - Time Based Services
 - Split/Shared Services
 - Copy and Paste
 - Medical Necessity and Labs
 - Prolonged Services

E/M – Key Components



The History

- The history section of a note should include documentation of four areas:
 - Chief Complaint, aka CC – Required, tells us why the patient is being seen.
 - History of Present Illness, aka HPI – Required, explains how the CC is symptomatically affecting patient.
 - Review of Systems, aka ROS –tells us how the CC is affecting the body systems.
 - Past, Family and Social History, aka PFSH – tells how any pertinent previous history has or will affect the CC.

History of present illness - HPI

- A chronological description of the development of an illness/condition.
- Can be documented by following either the 1995 or 1997 guidelines.
- Scoring of HPI:
 - **Brief** – 1-3 elements (95/97 guidelines)
 - **Extended** – 4 or more elements (95/97 guidelines) OR 3 or more chronic conditions w/status (97 guidelines)

6 | HPI – 1995 Guidelines

- Based on certain “elements”
 - LOCATION – Where does it hurt?
 - QUALITY – What’s it doing? How does it feel?
 - SEVERITY – How bad? What out of 10 on the pain scale?
 - DURATION – How long?
 - TIMING – When is it a bother?
 - CONTEXT – What happened to cause this?
 - MODIFYING FACTORS – Anything make it better/worse?
 - ASSOCIATED SIGNS & SYMPTOMS

7 | HPI -1997 Guidelines

- 1997 guidelines gives more flexibility, especially for patients with chronic conditions
- Can be documented as is in the 1995 guidelines, OR . .
- Can be documented simply by listing three or more chronic conditions and their status.

Review of Systems - ROS

- Constitutional
- Eyes
- Ear, Nose, Mouth, Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary
- Neurological
- Psychiatric
- Endocrine
- Hematologic/Lymphatic
- Allergic/Immunologic

• Types of ROS:

- **None**
- **Pertinent** to 1 system
- **Extended**; 2 – 9 systems
- **Complete**; 10 or more system or “All others negative”.

ROS Documentation

- There are several ways to adequately document a ROS.
 - List each body system with any relevant findings.
 - List all positive patient responses and any pertinent negative findings.
 - List all positives and pertinent negatives with a statement of “all others negative” at the end of the ROS.
 - Obviously, if selecting this option, ALL other systems must have been reviewed to make such a statement.
 - Comments such as “unremarkable” and “non-contributory” are NOT acceptable.

10 | ROS documentation – cont'd

- It is acceptable for the patient to complete a questionnaire/form to be used as a ROS. However, the provider must document this to have been reviewed and reference the location of the form within the medical chart.
- It is also acceptable for the ancillary staff to document the ROS, again with the provider documenting their review of the documentation.
- Know your payer guidelines. . .
 - Example: CPT considers it “double-dipping” if you count documentation as an element towards your HPI and then also use that same documentation as part of your ROS. Certain payers do not follow this rule and they do NOT consider this “double-dipping”. They may allow you can count the same element towards your HPI and ROS.

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Past, family, and social history – PFSH

Social History

Past Medical History

- Current Medications
- Past Surgeries
- Past Illness/Injuries

- **Family History**

- Limited to immediate family
 - Parents
 - Siblings
 - Children

- Smoking/Alcohol Use
- Marital Status and/or living arrangements
- Sexual History
- Employment/Education

- **Scoring PFSH:**

- **Problem-Focused & Expanded**
Problem-Focused: None
- **Detailed:** One
- **Comprehensive:** 3/2

PFSH Documentation

- It is acceptable for the patient to complete a intake form to be used as a source of the patient's history. However, the provider must document this to have been reviewed and reference the location of the form within the medical chart.
- Unobtainable History – When a history can not be obtained for whatever reason (i.e. dementia, comatose, etc.); it is **imperative** for the provider to document that the history was unobtainable and why.
 - Again, know your payer guidelines . . . Some payers may allow for credit to be given for a COMPLETE PFSH when the history is documented as unobtainable and why.

13 Scoring the overall history

	Problem-Focused	Expanded Problem-Focused	Detailed	Comprehensive
HPI	1-3	1-3	4+ or 3 chronic	4+ or 3 chronic
ROS	None	1	2-9	10+ or "All others negative"
PFSH	None	None	1	3/2

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Examination - Exam

- Can be documented by following either 1995 or 1997 guidelines.
- Exam tells us the provider's objective findings.
- MUST be performed by provider, not ancillary staff.
- Documentation such as "unremarkable" and "non-contributory" does NOT meet documentation requirements.
- Documentation such as "negative" or "normal" DOES meet documentation requirements.
- Documentation revealing abnormal findings must state what the abnormality is.
 - It is not acceptable to simply state "abnormal" and not elaborate on the abnormal findings.

15 | Exam – 1995

- Based on body areas (BA) or organ systems (OS).
- Some exams are simple observations.
 - Example: Patient is well nourished, well developed, alert and oriented x 3, in no acute distress.
 - Credit would be given for three organ systems for this statement. Constitutional, Neurologic and Psychiatric.
- Four different levels of an exam:
 - **Problem-Focused:** Focuses on only the BA or OS affected by the CC.
 - **Expanded Problem-Focused:** Focuses on the affected BA or OS, but also includes other related BA/OS as well.
 - **Detailed:** The affected BA or OS is thoroughly examined along with other affected BA/OS.
 - **Comprehensive:** BA's cannot be counted as documentation of a comprehensive exam, only OS's.
 - Important Note: 1995 guidelines do NOT state that any system/area needs to be documented in a certain way, meaning each system doesn't have to be documented in detail.

Exam - 1997

- More stringent than the 1995 guidelines.
- Exam is scored based on how many bullets are examined within each body system/area.
- Exams are scored as follows:
 - **Problem-Focused:** 1-5 elements identified by a bullet.
 - **Expanded Problem-Focused:** At least 6 elements identified by a bullet.
 - **Detailed:** 9/12 bullets must be properly documented and the affected area/system is examined in detail.
 - **Comprehensive:** Documentation of all areas identified by a bullet in the shaded areas and at least 1 bullet in every non-shaded area.

17 | Medical Decision Making - MDM

- Same guidelines for 1995 or 1997 guidelines.
- MDM section contains 3 areas of documentation:
 - Diagnosis – Number and status of diagnoses being treated.
 - Complexity – Number of tests and/or procedures being ordered or reviewed.
 - Risk – Level of risk which is assigned to the diagnoses being treated.

MDM – Diagnoses Treated

- It is **IMPERATIVE** that the provider document the diagnoses being treated, no more, no less.
- Provider Education Opportunity – They can not and will not, if audited, get credit for mentioning diagnoses that are not applicable to the day's visit.

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MDM – Diagnoses treated – cont'd

- Diagnoses are scored as follows:
 - Self-limited or minor (stable, improved, or worsening) (MAX 2) = 1 point per dx.
 - Established problem; stable, improved = 1 point per dx.
 - Established problem; worsening = 2 points per dx.
 - New problem; no additional workup planned (MAX 1) = 3 points per dx.
 - New problem; additional workup planned = 4 points per dx.

MDM – Complexity of Data

- Credit will be given for the ordering/reviewing of tests/procedures as follows:
 - Review and/or order clinical lab tests (80000) = 1 point
 - Review and/or order radiology tests (70000) = 1 point
 - Review and/order tests in medicine section (90000) = 1 point
 - Decision to obtain old records and/or obtaining history from someone other than patient = 1 point
 - Discussion of test results with performing physician = 1 point
 - Review and **summarization** of old records and/or obtaining history from someone other than patient and/or discussion of case with another health provider = 2 points
 - Independent visualization of image, tracing or specimen itself (not simple review of report) = 2 points

21 | MDM – Level of Risk

- The level of risk MUST be assigned to each encounter as it mirrors the medical necessity of the documentation.
- The level of risk is broken down into 3 categories:
 - Presenting Problem
 - Diagnostic Procedure
 - Management Options
 - The highest level selected, within the above three areas, indicates the level of risk.

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- When scoring the overall MDM; one of the three areas can be omitted if needed.
- Level is determined with 2-3 or center level.

Level of MDM	Straight-forward	Low	Moderate	High
Diagnosis	1	2	3	4 or more
Complexity	1 or less	2	3	4 or more
Risk	Minimal	Low	Moderate	High

MDM Calculators May Not = Medical Necessity

- Use caution when employing the use of coding or auditing tools. They often up-code the visits when it comes to calculating medical decision making. They are *TOOLS* and only meant to aid in determining the code.
- Tools miss the most important step in selecting a code – they cannot gauge medical decision making
 - Select visit based on documentation found in history and exam
 - Example comprehensive history, comprehensive exam, low medical decision making = 99215

History	Problem Focused	Expanded	Detailed	Comprehensive
Exam	Problem Focused	Expanded	Detailed	Comprehensive
MDM	Straight Forward	Low	Moderate	High
Level	99212	99213	99214	99215

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Note # 1

Coded as 99203

Per the documentation, what is the correct level of service?

- Undercoded?
- Overcoded?
- Why?

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Note # 2

Coded as 99215

Per the documentation, what is the correct level of service?

- Undercoded?
- Overcoded?
- Why?

Time Based Coding



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Time Based Coding per CPT

- When counseling and/or coordination of care dominates (more than 50%) the encounter with the patient and/or family, then time shall be considered the key or controlling factor to qualify for a particular level of service.

Examples

- ✓ Discussion of treatment options *at length*
- ✓ Patient returns to discuss diagnostic results
- ✓ Counseled on long term medication use and/or review narcotic contract
- ✓ Noncompliance
- ✓ UDS inconsistent results
- ✓ Life style changes – risk reduction measures

Time Based E/M Coding

- Office setting
 - ONLY count face to face time w/the patient
- OP/IP hospital setting
 - Can be floor time. Must be dedicated to the case, and just as the descriptor reads; “floor”. (Be careful about payor guidelines which may not match up with CPT descriptions.)
- Documentation principles
 - *There is still an expectation of history, exam and MDM*

Time Based E/M Coding

- The extent of counseling and/or coordination of care must be documented in the medical record.
 - Not a canned statement – make it specific to the patient
- Regardless of the time spent, the E/M level must still be medically necessary based upon the complexity of the patient's case
- The total time spent, and an indicator that greater than 50% was spent counseling/coordinates care must be documented
 - “30 of the 45 minute visit was spent counseling the patient on the above”.
 - “The entire 45 minutes was spent counseling the patient on the abnormal lab and radiology results”

Documentation for Medical Necessity Using Time

- Spell out what areas the patient was counseled on:
 - Diet, exercise, weight loss
 - Risk reduction measures
 - Medication, side effects, etc.
- Coordinated care with:
 - Home health
 - Hospice
 - Transfer care to other physician/facility

Prolonged Services



Prolonged Services

Face to Face, office or outpatient

- 99354, first 30 -74 minutes
 - (30 minute threshold) (doesn't have to be continuous)
- + 99355, each additional 30 minutes
 - (15 minute threshold) (doesn't have to be continuous)
- Consideration must be given to the time spent on the primary procedure or E/M

Prolonged Services

NON Face to Face

- 99358, office or outpatient, first 30 -74 minutes
 - (30 minute threshold) (doesn't have to be continuous)
- + 99359, office or outpatient, each additional 30 minutes
 - (15 minute threshold) (doesn't have to be continuous)
- Consideration must be given to the time spent on the primary procedure or E/M

Prolonged Services Examples

- Time spent researching
- Time spent reviewing old records
- Phone calls to other healthcare providers

Split/Shared Visits



What CMS Says...

- *“A split/shared E/M visit is defined by Medicare Part B payment policy as a medically necessary encounter with a patient where the physician and a qualified NPP each personally perform a substantive portion of an E/M visit face-to-face with the same patient on the same date of service. A substantive portion of an E/M visit involves all or some portion of the history, exam or medical decision making key components of an E/M service. The physician and the qualified NPP must be in the same group practice or be employed by the same employer.”*

Documentation

- The physician and the NPP each personally perform a substantive portion of an E/M visit (face to face encounter) with the patient on the same day “A substantive portion of an E/M visit involves: all or some portion of the history, exam or medical decision making key components of an E/M service.”
- The encounter must consist of more than a review of the medical record by the physician.
- The medical record should contain enough detail to allow a reviewer to:
 - Identify both providers
 - Link the physician notes to those of the NPP
 - Include legible signatures from both providers
 - Confirm that the physician and the NPP both saw the patient face-to-face
 - Include legible/electronic signature

Shared Service

- Both physician and NPP are employed by same entity.
- Physician face-to-face is clearly documented.
- Be sure there are no payor regulations that might prohibit shared billing.
- Not applicable in the SNF (CMS IOM 100-4, ch 15, 30.6.13.h).
- Common place of service-
 - OP hospital
 - Inpatient
 - ER
- Applied to services in which both the physician and the NPP see the patient and perform substantial portions of the visit
- Not applicable to the office setting
 - Except..... When incident-to is met
- *Remember: New patients never qualify as incident-to*

Office/Clinic Setting

In an office setting, criteria for a split/shared can be difficult to meet.

- It cannot be:
 - A new patient
 - Time based
 - A new problem
- When the physician performs the E/M service report it using the physician's UPIN/PIN.
- When a service is a split/shared between a physician and a non-physician practitioner (NP, PA, CNS or CNM), the service is considered to have been performed "incident to" if the requirements for "incident to" are met and the patient is an established patient.
- If "incident to" requirements are not met, the service must be billed under the NPP, and payment will be made at the appropriate physician fee schedule payment.

Weighing the Risks vs. Benefits of Split/Shared

- **Benefits**

- Provides comprehensive services in the appropriate settings
- Frees up the physician for other complex cases
- Reimbursed at 100% of physician fee schedule
- Shared documentation

- **Risks**

- Misunderstanding of rules
- Documentation not supportive
- Confusion with “Incident-to Services”
- Mixing supervision requirements of other payors

Incident-to Definition

Quick Refresher

- An integral, although incidental, part of the physician's professional service.
- Commonly rendered without charge or included in the physician's bill.
- Of a type that are commonly furnished in a physician office or clinic.
- Furnished by the physician or by auxiliary personnel under the physician's direct supervision.

Incident-to Billing

1. Employed staff providing service
2. Established patient
3. Physician initiated treatment plan and remains active
4. Subsequent visits follow plan
5. Supervision requirements met
6. No new problems addressed
7. POS 11
8. Documentation present
9. Initiating physician (ordering) name reported on claim form

Quick Refresher

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Shared Service Checklist



Employed staff
participating in the care



Appropriate setting



Physician **face-to-face**



Documentation present
by billing physician



Signed by both
providers

WPS Medicare – Unacceptable Documentation

I have personally seen and examined the patient independently, reviewed the PA's Hx, exam and MDM and agree with the assessment and plan as written" signed by the physician

"Patient seen" signed by the physician

"Seen and examined" signed by the physician

"Seen and examined and agree with above (or agree with plan)" signed by the physician

"As above" signed by the physician

Documentation by the NPP stating "The patient was seen and examined by myself and Dr. X., who agrees with the plan" with a co-sign of the note by Dr. X

No comment at all by the physician, or only a physician signature at the end of the note



*The **physician** and NPP must personally perform and document a substantive portion of the visit. A substantive portion involves **all or some** portion of the history, exam or medical decision making **key components** of an E/M service."*

Shared Services (recap)

1. Employed staff participating in the care
2. Appropriate setting
3. Physician **face-to-face**
4. Documentation present by billing physician
5. Signed by both providers

Copy and Paste



Documentation Software Templates

Noridian Part B MR has noted that some Electronic Medical Record (EMR) software programs auto-populate certain aspects of the medical record with information that is not patient specific. This issue is more profound in the HPI when discussing the context of a certain illness and/or co-morbidity.

Documentation to support services rendered needs to be patient specific and date of service specific. These auto-populated paragraphs provide useful information such as the etiology, standards of practice, and general goals of a particular diagnosis. However, they are generalizations and do not support medically necessary information that correlates to the management of the particular patient. Part B MR is seeing the same auto-populated paragraphs in the HPI's of different patients. ***Credit cannot be granted for information that is not patient specific and date of service specific.***

Non-Patient Specific Information in Documentation - WPS GHA

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

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

Disclaimers Used as Part of Physician's Signature

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

The Bad Note



- Defaulted findings
- History and ROS contradictory
- Shared template
- Copy and paste
- Lack of description
- Over documented
- Unable to identify who contributed to the note

The Good Note



- Presenting problem clearly stated
- PFSH appropriate
- ROS and Exam patient specific
- Provider thought process obvious
- Care plan generates appropriate follow-up
- Note identifies the contributors

Medical Necessity and Labs



Categories of Testing

- Screening
 - No established diagnosis
 - No signs or symptoms
- Diagnosing
 - There are signs and/or symptoms
- Monitoring
 - There is a diagnosis
 - There is treatment, care plan or medication

Diagnosis Coding – the Order

- Code what is known at the time lab is ordered
 - Cannot code “rule/out”, “suspect”, etc.
 - Instead code signs or symptoms
- Report appropriate Z code for an encounter where the patient is seen for routine lab testing with no signs, symptoms or associated diagnosis. Report appropriate examination code for screening or surveillance
 - Example - Z00.00, Z13.-

Diagnosis Coding – Subsequent Visits

- Code any confirmed or definitive diagnoses documented in the lab report
- ICD-10-CM sequencing
 - Diagnosis
 - Condition
 - Problem
 - Other (reason for encounter/visit)
- Other diagnoses may be sequenced as secondary codes

Preventive and Wellness Visits



“What fits your busy schedule better, exercising one hour a day or being dead 24 hours a day?”

AMA CPT® Guidelines - Preventive

- If an abnormality is encountered or a preexisting problem is addressed in the process of performing this preventive medicine evaluation and management service, and if the problem or abnormality is significant enough to require additional work to perform the key components of a problem-oriented E/M service, then the appropriate Office/Outpatient code 99201-99215 should also be reported. Modifier 25 should be added to the Office/Outpatient code to indicate that a significant, separately identifiable evaluation and management service was provided on the same day as the preventive medicine service. *The appropriate preventive medicine service is additionally reported.*
- An insignificant or trivial problem/abnormality that is encountered in the process of performing the preventive medicine evaluation and management service, and which does not require additional work and the performance of the key components of a problem-oriented E/M service, should not be reported.

The Standard Preventive E/M visit

- Services for a 25-year-old healthy female will be very different from those for a 55-year-old male or female, but the general components of a preventive medicine visit according to CPT's preventive medicine services codes (99381-99397) remain the same:
 - A comprehensive history and physical examination,
 - Anticipatory guidance, risk factor reduction interventions or counseling,
 - The ordering of appropriate immunizations or laboratory/diagnostic procedures,
 - Management of insignificant problems.

Key Points

Refilling medications and ordering lab at a preventive service does not automatically support billing a problem focused E/M service.

A preventive service is the only visit that does not require a “chief complaint”.

All ages are entitled to a preventive service, not all payors will cover it.

Not all payors reimburse a preventive and problem-oriented services on the same date

Medicare does not reimburse for preventive medicine services codes; it does cover some screening services.

If a Medicare beneficiary receives a Preventive 99387 or 99397; apply a carve-out for any covered services provided.

Documentation

- The comprehensive history and examination performed during a preventive medicine encounter are not the same as the comprehensive history and exam that are required for certain problem-oriented E/M codes.
- The history does not involve a chief complaint or history of present illness.
 - It includes
 - A comprehensive review of systems;
 - A comprehensive or interval past, family and social history;
 - A comprehensive assessment/history of pertinent risk factors.
- The preventive-visit exam is multisystem; the content and extent of the exam is based on the patient's age, gender and identified risk factors.

60 | Documentation

Age-appropriate counseling and discussion of issues common to the age group are also included in the preventive medicine services.

- Issues related to contraception are discussed with women of child-bearing age.
- Anticipatory guidance is given to parents of pediatric patients.
- Review of safety issues
- The need for screening tests and discussions about the status of previously diagnosed stable conditions are also part of the comprehensive preventive medicine service.

Add on Services

- Although a part of preventive services, remember to separately bill for:
 - Immunizations, or
 - Laboratory
 - Diagnostic procedures
- Insignificant problems may be addressed as part of a preventive visit. For example, a patient seen in the spring or fall might request a prescription renewal for allergy medications. Unless significant work is required to assess this complaint, writing the prescription is included in the preventive medicine services code.

THE STANDARD PREVENTIVE E/M SERVICE: AN EXAMPLE

A 28-year-old established patient comes to your office for her well-woman examination. You take the patient's interval medical, family and social history and perform a complete review of systems. You also perform a physical examination that includes a blood-pressure check and thyroid, breast, abdominal and pelvic examinations, and you obtain a Pap smear. The patient is on oral contraceptives and has concerns about intermittent break-through bleeding. You counsel the patient regarding alternatives and give her a prescription for a new medication. You also counsel the patient about diet, exercise, substance abuse and sexual activity. Then you send the Pap smear to an outside laboratory that will bill the test directly to the payer. Although the patient has concerns about her current method of birth control, the associated counseling and change in medication is considered part of the preventive medicine service for her age group, so you should submit 99395, "Periodic comprehensive preventive medicine ..., established patient; 18-39 years," and ICD-910 code Z01.419, "Gynecological examination."

<u>Bill</u>	<u>Diagnosis code(s)</u>	<u>Procedure code(s)</u>
Patient	Z01.419 Gynecological service	99395 Preventive service

THE PREVENTIVE E/M VISIT WITH A PROBLEM-ORIENTED SERVICE: AN EXAMPLE

A 52-year-old established patient presents for an annual exam. When you ask about his current complaints, he mentions that he has had mild chest pain and a productive cough over the past week and that the pain is worse on deep inspiration. You take additional history related to his symptoms, perform a detailed respiratory and CV exam, and order an electrocardiogram and chest X-ray. You make a diagnosis of acute bronchitis with chest pain and prescribe medication and bed rest along with instructions to stop smoking. You document both the problem-oriented and the preventive components of the encounter in detail. You should submit 99396, "Periodic comprehensive preventive medicine ..., established patient; 40-64 years" and ICD-10 code Z00.01, "Routine general medical examination at a health care facility"; and the problem-oriented code that describes the additional work associated with the evaluation of the respiratory complaints with modifier -25 attached, ICD-10 codes J20.9, "Acute bronchitis" and R07.9, "Chest pain" and the appropriate codes for the electrocardiogram and chest X-ray.

<u>Bill</u>	<u>Diagnosis code(s)</u>	<u>Procedure code(s)</u>
Patient	Z00.01 Routine exam w/abnormal findings	99395 Preventive service
	J20.9 Acute bronchitis	99213-25* E/M service
	R07.9 Chest pain	93000 EKG
		71020 Chest x-ray PA/L

THE PREVENTIVE VISIT FOR A MEDICARE PATIENT: EXAMPLES

A 65-year-old established Medicare patient presents for her annual well-woman exam. Medicare covers the collection of a screening Pap smear and her pelvic exam and clinical breast check for that year. You should submit the following codes (and related charges) to Medicare: G0101 for the pelvic exam and clinical breast check, Q0091 for the collection of the Pap smear specimen and Z12.9 "Special screening for malignant neoplasms; cervix"; and the following codes (and related charges) to the patient: 99397, "Periodic comprehensive preventive medicine ... established patient, 65 years and over," and Z1.419, "Special investigations and examinations; gynecological examination" and Z12.9, "Special screening for malignant neoplasm." The total amount billed and received for this visit should equal your usual charge for an annual exam of \$100.

<u>Bill</u>	<u>Diagnosis code(s)</u>	<u>Procedure code(s)</u>
Patient	Z12.9 Special screening for malign neo Z01.419 Gynecological exam	G0101 Pelvic exam/breast/neck Q0091 Collection pap smear 99397 Preventive service

Advanced Wellness Visit - AWW

What the AWW Is

- A chance to spend time learning about your patient's lifestyle, needs, and expectations for their future health.
- The opportunity to uncover social issues and unrecognized health issues that affect the patients daily life.
- A time to discuss options for maintaining or improving health.

What the AWW is not

- Not a head-to-toe physical exam unless indicated
- Not focused on known problems already managed
- Not time for a laundry list of unaddressed problems

Who Can Provide an AWW

- A physician who is a doctor of medicine or osteopathy; or
- A physician assistant, nurse practitioner, or clinical nurse specialist; or
- A medical professional including a health educator, a registered dietitian, or nutrition professional, or other licensed practitioner or a team of such medical professionals, working under the direct supervision (i.e. in the office suite and available if needed) of a physician.

Required AWW Components at a Glance

1. Medical and family history
2. List of current providers and suppliers
3. Height, weight, BMI, BP
4. Detection of any cognitive impairment
5. Screening for depression
6. Assessments of hearing, self-care abilities, fall risk, home safety
7. 5-10 year preventive service plan (written)
8. List of risk factors and interventions
9. Health advice and referrals

Resources

- <http://www.fcsso.com>
- <http://www.palmettogba.com/palmetto/palmetto.nsf/DocsCat/Home>
- <https://www.novitas-solutions.com> (previously Highmark)
- <http://www.cgsmedicare.com/> (previously Cigna)
- <http://www.ngsmedicare.com/wps/portal/ngsmedicare>
- <http://www.cms.gov/home/medicare.asp>
- <https://www.cms.gov/home/regsguidance.asp>
- <http://www.cms.gov/apps/physician-fee-schedule/>
- www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part4.pdf

Resources

- <http://www.aafp.org/fpm/2006/0900/p56.html>
- <http://www.aafp.org/fpm/toolBox/viewToolBox.htm>
- <http://www.aafp.org/fpm/2002/0400/fpm20020400p51-rt1.pdf> WW
- https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/Downloads/MPS_QuickReferenceChart_1.pdf
- <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MLNPrevArticles.pdf>
- <https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/ProviderResources.html>

Last on this list is the most comprehensive.




Thank you!

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Patient: Handy Manny DOB: 4/8/07

Date of Visit: 2/4/13

Provider: Doc McStuffins, M.D.

CC

Stuffy nose

HPI

New patient presents to clinic accompanied by mother with complaints of nasal congestion. The nasal congestion has been present for 3 days and seems most bothersome during the night while trying sleep. Mom has placed a humidifier in patient's room which seems to offer slight relief. Patient and mom also report mild cough.

ROS

CONS: No fever, No fatigue

EYES: No redness or discharge

ENMT: Positive nasal congestion, Positive nasal discharge

CARDIO: Negative

RESP: Positive occasional cough

LYMPH: No swollen lymph glands

PFSH

Not Obtained

Exam

VITALS: B/P 120/80; pulse 96; O2 sat 97% on room air

GENERAL: 6 y/o male who is well nourished and well developed.

EYES: PERRL

HEENT: Normocephalic, atraumatic.

Ears: Bilateral; tympanic membranes are clear.

Nose: Nasal discharge present; thick, yellow in color. Slight sinus tenderness.

Throat/Mouth: No exudate present. Oral mucosa is moist.

CARDIO: Regular rate and rhythm.

RESP: CTA bilaterally. No wheezes, crackles or rhonchi.

SKIN: No rashes or edema noted.

Plan

Acute Sinusitis

We will treat patient with over the counter decongestants and twice daily saline updraft inhalation treatments. If no relief in 1 week, he is to return to the clinic.

Electronically signed and authored by: Doc McStuffins, M.D. on 2/4/13 at 3:43 pm.

Patient: Samuel Sickly DOB: 1/30/44

Date of Visit: 2/3/14
Provider: Cathy Chronic, M.D.

CC

HTN, Heart disease, Hyperlipidemia

HPI

HTN: Stable on Lisinopril and Coreg.
Organic heart disease: Stable.
Hyperlipidemia: Improving on Lovastatin.

ROS

CONS: Positive fatigue
CARDIO: Negative
RESP: No chest pain
ENDO: Negative
ALL OTHERS NEGATIVE

PFSH

Medical: HTN, DJD, Hyperlipidemia, Organic heart disease.
Family: Father with prostate cancer.
Social: Current tobacco use, occasional alcohol use.

Exam

VITALS: B/P **148 HIGH** /80; pulse 64; O2 sat 98% on room air.
GENERAL: 69 y/o male who is well nourished & well developed. Alert & oriented x 3. No acute distress.
RESP: CTA bilaterally. Respirations are non-labored. Breath sounds are equal. Symmetrical chest wall expansion. No chest wall tenderness.
CARDIO: Normal rate. Regular rhythm. No murmur. No gallop.
GI: Soft, non-tender, non-distended. Normal bowel sounds. No organomegaly.
LYMPH: No cervical adenopathy.

Plan

HTN, Organic Heart Disease, Hyperlipidemia
By all accounts, patient is doing well at current time. He is to continue Lisinopril 5 mg PO BID and Coreg 6.25 mg PO BID for his HTN and organic heart disease. Also, to continue Lovastatin 20 mg PO daily for treatment of hyperlipidemia. I have sent this prescription to Wal-Mart pharmacy. I will see him back in clinic in 3 months.

Electronically signed and authored by: Cathy Chronic, M.D. on 2/3/14 at 11:47 am.

AUDIT WORKSHEET

CC.

	Problem Focused	Exp. Prob. Focused	Detailed	Compre-hensive	
HISTORY	HPI (history of present illness) Elements: ___ Location ___ Severity ___ Timing ___ Modifying factors ___ Quality ___ Duration ___ Context ___ Associated signs and symptoms	Brief (1-3)	Brief (1-3)	Extended (4+)	Extended (4+)
	ROS (review of systems): ___ Constitutional (wt loss, etc) ___ Ears, nose, mouth, throat ___ Eyes ___ Card/vasc ___ Resp ___ GI ___ Musculo ___ Psych ___ Integumentary (skin, breast) ___ Endo ___ Hem/Lymph ___ All/Imm ___ "All others negative"	None	Pertinent to problem (1 system)	Extended (2-9 systems)	Complete (10+ or some systems w/ statement "all others negative")
	PFSH (past medical, family, social history): ___ Past history ___ Family history ___ Social history	None	None	Pertinent (1)	Complete* (2 or 3)
EXAM	Body Areas: ___ Head, incl. face ___ Neck ___ Chest, incl. breasts and axillae ___ Abdomen ___ Genitalia, groin, buttocks ___ Back, incl. spine ___ 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) ___ Ears, nose, mouth, throat ___ Eyes ___ Cardiovascular ___ Resp ___ GI ___ GU ___ Musculo ___ Skin ___ Neuro ___ Psych ___ Hem/Lymph/Imm				

* Complete PFSH: 2 hx areas: a) Est pts office (outpt) care; domiciliary care; home care b) Emergency dept c) Subseq nursing facility care
 3 hx areas: a) New pts office (outpt) care; home care b) Consultations c) Initial hospital care d) Hospital observation
 e) Compre nursing facility assessments

Circle history and exam type within appropriate grid under Level of Service

Number of Diagnoses or Treatment Options				
A	B	X	C	= D
Problems to Exam Physician	Number	Points	Result	
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 addl workup planned	Max=1	3		
New problem (to examiner); addl workup planned		4		
TOTAL				
Bring total to line A in Final Result for Complexity				
Amount and/or Complexity of Data to Be Reviewed				
Data to Be Reviewed	Points			
Review and/or order of clinical lab tests	1			
Review and/or order of tests in the radiology section of CPT	1			
Review and/or order of tests in the medicine section of CPT	1			
Discussion of test results with performing physician	1			
Decision to obtain old records and/or obtain history from someone other than patient	1			
Review and summarization of old records and/or obtaining history from someone other than patient and/or discussion of case with another health care provider	2			
Independent visualization of image, tracing, or specimen itself (not simply review of report)	2			
TOTAL				
Bring total to line C in Final Result for Complexity				
Final Result for Complexity				
A Number diagnoses or management options	≤ 1 Minimal	2 Limited	3 Multiple	≥ 4 Extensive
B Highest risk	Minimal	Low	Moderate	High
C Amount and complexity of data	≤ 1 Minimal or low	2 Limited	3 Moderate	≥ 4 Extensive
Type of decision making	Straight-forward	Low Complex.	Moderate Complex.	High Complex.

Risk of Complications and/or Morbidity or Mortality			
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	*Lab tests requiring venipuncture *Chest x-rays *EKG/EEG *Urinalysis *Ultrasound, e.g. echo *KOH prep	*Rest *Gargles *Elastic bandages *Superficial dressings
	*Two or more self-limited or minor problems *One stable chronic illness, e.g. well-controlled HTN or DM, cataract, BPH *Acute uncomplicated illness or injury, e.g. cystitis, sprain, allergic rhinitis	*Physiologic tests not under stress, e.g. pulmonary function tests *Non-cardiovascular imaging studies with contrast, e.g. barium enema *Superficial needle biopsies *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. pneumonitis, colitis *Acute complicated injury, e.g. 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 *CV imaging studies with contrast and no identified risk factors, e.g. arteriogram, cardiac cath *Obtain fluid from body cavity, e.g. lumbar puncture, thoracentesis	*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 of dislocation without manipulation
	*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, psychiatric illness w/ potential threat to self or others, ... *An abrupt change in neurologic status, e.g. seizure, TIA, weakness, sensory loss	*Cardiovascular imaging studies with contrast with identified risk factors *Cardiac electrophysiological tests *Diagnostic endoscopies with identified risk factors *Discography	*Elective major surgery (open, percutaneous, or endoscopic) with identified risk factors *Emergency major surgery (open, percutaneous, or endoscopic) *Parenteral controlled substances *Drug therapy requiring intensive monitoring for toxicity *Decision not to resuscitate or to de-escalate care due to poor prognosis
HIGH			

Bring result to **line B** in Final Result for Complexity

Patient Name: _____

Physician: _____

Date of Service: _____

Level of Service: _____