How Often Does Improper Evaluation and Management Coding Occur in a Family Practice Setting?

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Abstract

Context: Choosing the correct E&M code for most providers is a difficult and misunderstood process. As a result improper coding occurs and can result in fraud charges. Many providers are unaware mistakes are being made and as a result improper coding occurs on a daily basis. More than 10% of total Medicare payments in the fiscal year 2004 were improper, according to a CMS report. This resulted in either too much or too little money going to doctors and other program participants.

Objective: This project was designed to evaluate the coding accuracy and the documentation performed by four family medicine providers in a community setting in northern Idaho to determine the frequency at which improper coding occurs in a typical family practice setting. Determining the frequency of improper coding will demonstrate if there is a need for providers to become more familiar with coding guidelines. In addition this project attempted to determine the potential financial impact incurred by a practice as result of improper coding. The ultimate goal would be to identify methods where by providers could be advised where coding and documenting mistakes can be avoided in the future.

Design: The clinic identified in the project, has a policy where each individual provider assigns his or her own E&M code after each patient visit. Ten chart notes from the first office day in May, 2005 were randomly selected from each provider. I chose to evaluate only one day's chart notes, as this sample would represent a typical day. Ten chart notes from four different providers were used, totaling forty notes. The chart notes were evaluated first according to documentation. Specifically, I evaluated the inclusion of the following: chief complaint, history of present illness, pertinent past medical history, physical exam and medical decision-making. All the chart notes were reviewed in the same fashion using a checklist computerized palm program called Stat Coder. This program assigns the correct E&M code according to current documentation as identified by the Health Care Financing Administration. Stat Coder makes this process more straightforward with automated checklists that count the documentation elements of a patient visit for you. A tally was kept of how many charts were coded improperly, either up-coded or down-coded and how many were coded correctly.

Setting: This project was conducted at a busy family practice in northern Idaho.

Subjects: Charts were selected at random. Subjects eliminated from the study were new patients, patients who had a physical, all pregnant patients and patients who were under the age of 18.

Results: Ten chart notes for four providers were reviewed, totaling forty charts. Eighteen (45%) chart notes were coded correctly. Fifteen (37.5%) chart notes were upcoded and seven (17.5%) charts were down-coded. Two hundred and twenty seven dollars was lost due to seven chart notes being down-coded. Whereas, the up-coding of fifteen chart notes led to the over billing of three hundred and thirty two dollars.

Conclusions: It was shown that improper coding occurs greater than 55% of the time in a typical day. These errors led to financial losses of $227.00 and $332.00 was billed out when it shouldn't have been. Imagine the losses incurred over the entire year. If you assume there are 260 working days in a year and if this happens daily, than $59,020 was lost and $86,320 was over-billed. It wasn't expected that down-coding would occur at a greater rate that up-coding, but this study showed providers tend to up-code rather than down-code. It is important to note that the results could vary according to practice and provider and this design lacked a large sampling pool, which could change the results dramatically. More research needs to be done, to determine where the majority of errors are made and what can easily be corrected to prevent these errors in the future.
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How often does improper Evaluation and Management coding occur in a family practice setting?

By:

Katie Klein PA-S
August 16, 2005
Final Version

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Faculty Advisor: Mary Von PA-C
Clinical Project Advisor: Jonathon W Gietzen MS PA-C
Project Mentor: Dr. Morgan Ford, Post Falls Family Medicine
Biography

Katie Klein was born in Nampa, Idaho. Shortly thereafter her family moved to Spring Creek, Nevada where Katie remained for the next 15 years. While in Nevada she was active in sports, including cross-country and track. She also raised registered Suffolk sheep and showed them professionally for over 10 years. In addition, she served as the Nevada State FFA President in 1998 and competed in many public speaking competitions.

Later, she attended the University of Nevada for her first year of college and began volunteering her time as an athletic trainer. As an athletic trainer she was able to learn more about sports medicine and developed rehabilitative programs for injured athletes. After transferring to the University of Idaho, she continued to work with the football and women’s basketball team.

While attending the University of Idaho, she joined the Kappa Kappa Gamma sorority and was an active student on campus. She also volunteered her time as a physical therapy aide and later as a recreational therapy aide at the Shriner’s Children’s Hospital in Spokane, Washington. She graduated in 2001 with a Bachelor of Science in Physical Education and majored in Sport Science.

After college she worked as a certified nursing assistant at a family practice in Post Falls, Idaho. During her employment she was able to work with several doctors, a nurse practitioner, and a physician assistant. The PA profession became very appealing as a career option and Katie began applying to PA schools across the country.

She was accepted to Pacific University and began their Master’s program the summer of 2003. She will graduate this August with a Master’s of Science and plans on working at a family practice in Kellogg, Idaho.
Abstract

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List of Abbreviations

BP: Blood Pressure
Bs: bases (referring to base of lungs)
Clr: Clear
CONST: Constitutional
CMS: Centers of Medicare and Medicaid Services
D.O.: Doctor of Osteopathy
EACs: External auditory canals
E&M: Evaluation and Management
EOMI: Extra-occular movements intact
FBS: Fasting blood sugar
FFS: Fee For Service
F/U: Follow-up
HEENT: Head, Ears, Eyes, Nose and Throat
HPI: History of Present Illness
JVD: Jugular venous distention
M.D.: Medical Doctor
NIDDM: Non Insulin Dependent Diabetes Mellitus
Nl: Normal
OA: Osteoarthritis
P: Pulse
PERRLA: Pupils equal, round, reactive to light and accommodation
PFSH: Past Family, Social History
q.a.m.: Every morning

RBRVS: Resource Based Relative Value Scale

RESP: Respirations

ROS: Review of Systems

RTC: Return to clinic

SOB: Shortness of Breath

TMs: Tympanic membranes

UA: Urinanalysis

w/: with

WNL: Within normal limits

w/o: without

Wt: Weight
How often does improper Evaluation and Management coding occur in a family practice setting?

**Introduction:**

Medical providers are taught extensively in the nuances of medicine, the depth of pathophysiology, and the breadth of pharmacology. However, few providers develop competency in the financial aspects of their daily work until well after they finish their respective training programs. It is assumed that most providers have gained experience learning the E&M (Evaluation and Management) coding system ‘on the job’ through trial and error. Many medical providers are left selecting an E&M code and documenting their findings without the proper knowledge of how this code should be determined.¹⁴ E&M coding practices can be overwhelming and intimidating for even the most seasoned clinician. However, once a foundation of coding knowledge has been laid, it is anticipated that a provider should be able to code and document correctly with confidence. This project attempted to determine how frequently E&M coding mistakes occur in a typical family practice setting and to develop strategies were these mistakes can be avoided in the future for the benefit of the provider, practice, and the patient.

**Problem Statement:**

Every time a patient is seen by a medical provider and evaluated, they are assigned a diagnoses and E&M code for that visit. This code determines what amount the patient will be billed for the visit. In general, the more complex the clinic visit was, the higher the E&M code that is allowed to be charged. The codes are broken into five sections for established patients, they are: 99211, 99212, 99213, 99214, and 99215. Higher codes result in more money being generated than lower codes. For example, a 99214 will cost more for the patient than a 99213. The E&M code is a cumulative decision based on the relative complexity of the history, physical
Within these three categories, certain components must be included according to which E&M code was chosen. Refer to Table III: The 3 Key Component Coding Guidelines, for more detail. For example, a 99213 code must pertain to an established patient of low complexity. The history must be documented to include their chief complaint, history of present illness, and one review of systems. The physical exam documentation must include a minimum of 2 systems or 6-11 elements. A higher code, such as a 99214 would include a more in-depth history, more systems, and moderate complexity. A more detailed example is given below taken from American Academy of Family Physicians website, from the article *Three Documentation Tools That Work.*

**S:** Mr. Doe returns today for a routine four-month F/U for evaluation and management of his NIDDM, hypertension and OA. No new complaints. He denies headache, visual changes, chest pain, SOB or extremity numbness. No increased joint pain. Dietary compliance good, and his BP and home glucose monitoring records indicate acceptable control of both.

**O:** CONST: BP 138/84, Wt 175, P 82 and regular.
HEENT: PERRLA, EOMI, EACs and TMs nl; oropharynx benign.
NECK: supple w/o JVD, bruits or thyromegaly.
RESP: BS clear to percussion and auscultation w/o retractions or rubs.
HEART: WNL w/o gallop, murmur, rub, click or irregularity.
EXT: distal pulses intact w/o cyanosis, clubbing or edema.
NEURO: DTR WNL and symmetric; no decreased lower extremity sensation noted.
LABS: FBS 132, UA WNL

**A:** 1. Stable NIDDM
2. Stable hypertension
3. Stable Osteoarthritis

**P:** 1. Glucotrol 5mg daily q.a.m.
2. Procardia XL 30mg daily.
3. Relafen 1,000mg daily.
4. Continue home glucose monitoring.
5. SMA-7and glycosylated hemoglobin today.
6. RTC for routing F/U in 4 months.

First, let’s look at the history. The patient has no new complaints to characterize, but since the current status of his three chronic conditions—diabetes, hypertension, and osteoarthritis—where addressed this allows for an extended HPI. The review of systems
includes questions about at least 6 systems and body areas: eyes cardiovascular, respiratory, musculoskeletal, neurologic, and endocrine. Addressing these areas allows for a detailed ROS.6,8 This note did not address the past, family or social history. Consequently, although the HPI and ROS seem to point to a detailed history, the actual level is limited to expanded problem focused.6,8 Note that simply reviewing the patient’s medication list and documenting that fact in the note would have counted as past history, therefore raising the PFSH to detailed and therefore the overall level of history to detailed.6,8

Second, the exam portion of the note documents the finding for eight systems and body areas, which as the table indicates, meets the requirement for a detailed exam, provided that at least 12 bulleted elements are documented in the note. Refer to Table IV: Physical Exam Elements.

Thirdly, because the history and the exam differ in level and this is an established-patient visit, the level of medical decision making will determine the level of the visit.6,8 The highest two of the three components determines the level of the visit.6,8 Refer to Table V: Medical Decision-Making to follow along. No new problems were reported, and each established, previously diagnosed problem (diabetes, hypertension, and osteoarthritis) were documented as being stable. Second, in evaluating the amount and complexity of data to be reviewed, we have only lab tests to consider. Finally, the level of risk seems to be moderate, both because the visit involves prescription drug therapy and because it concerns three stable chronic illnesses.6,8 Because the highest two of the three components determines the level of decision making, the level for this encounter is moderate complexity.6,8,9
To review, we have an expanded problem-focused history, a detailed exam and moderately complex decision making to evaluate. Because two of the three are enough to determine the level for an established patient visit, we end up with a code of 99214.6,7,8,9

E&M coding is more complicated than ever, and it is shown from the example above, that there are many components to remember when selecting the proper code. This however is just one of many reasons, why improper coding continues to occur on a daily basis. Weary of fighting with insurers, fearful of getting audited by Medicare, or merely unsure about what they can code for—for whatever reason, many physicians habitually down-code.1 However, their detailed chart note often reflects that a higher code should be billed. Bill Thrift, MD, a family physician in Prescott, Arizona says his office frequently undercodes claims after treating patients with multiple, complex problems while anticipating what insurers might reject.1 He also states “One of the hardest things for us to do is really charge what we’re worth, we’re not aggressive at working the system.”1 Researchers at the University of Wisconsin Medical School, found that family doctors manage an average of 3.05 problems per patient visit, but they record only 2.82 in the chart, and 1.97 on the bill.1 Down-coding results in lost monies for the practice and the simple fact that the provider is not getting paid for the work he/she has performed. If a study could quantify the amount of money lost due to down-coding over the years the provider is in practice, these numbers could be astronomical. The extent however is unknown, due to limited research in the area of E&M coding practices.

On the flip side, provider’s confusion also can also lead to up-coding. This confusion about which codes to use for services contributed to estimated overpayments of more than $20 billion to various program participants.8,11 But nearly $1 billion stayed in the federal coffers when it should have gone to medical professionals, and the agency suspects that the same coding
confusion could be largely to blame. Reimbursement shortfalls to providers are thought to be linked to the frustration of selecting an E&M code.

**Background:**

Many doctors have the idea that only blatant mistakes can result in fraud charges. The difficulty can lie in the fact that the coding error was made in innocence. Congress amended the *False Claims Act* in 1986 to allow the government to prosecute when a person “acts in deliberate ignorance” of whether claims are accurate or not.

These innocent errors can result in the unfortunate situation of the provider’s word against an agent from the Office of the Inspector General. The following example is taken from an article entitled *Code with care: You’re being watched* from *Medical Economics.* The Galichia Medical Group is a 30-doctor multispecialty practice in Kansas. In response to a complaint from three whistleblowers working for the practice, Medicare audited 200 charts. The Feds concluded that the practice engaged in upcoding, medically unnecessary services, and duplicate billing. The doctors claimed that the problem was scattered documentation and not bad coding or fraudulent billing, however they decided to settle because it would have been too expensive to proceed, say Gary L. Ayers, the attorney who defended Galichia. The settlement called for the practice to pay fines of $1.5 million over six years.

“The way our charting system was structured, you had to look in several different locations in the chart in order to figure out what happened during a single patient visit,” say Vicki Dwyer, Galichia’s compliance officer. For example, when a patient came in for a 6 month follow-up of hypertension, the history of present illness and vital signs may have been noted on the progress note in the middle of the chart, while the actual finding from the physical exam would be in a letter to the referring physician in the back of the chart. The diagnoses and need for
follow-up visits and testing would be written on the charge ticket in the front of the chart. The Feds only looked at the progress note, so they wouldn’t notice the physical exam or the medical necessity documented on the charge ticket. That’s how CMS came up with allegations of duplicate charges and upcoding.  

As part of the practice’s settlement with the government, it agreed to enter into a “Corporate Integrity Agreement” with the OIG. In exchange for settling the action, the practice agreed to hire a compliance officer, develop written standards, implement an employee training program, and establish a confidential error disclosure program. The practice completely revamped its charting system and the new system is said to have made a huge difference. The doctors now use a template, which puts all the information about a patient visit on one sheet of paper. Organizing charts so an auditor can see the whole picture of the encounter and so he can see the medical necessity at a glance prevents communication misunderstandings and coding errors.  

Even if a doctor has a billing company or staff coders working for him or her, he or she is ultimately responsible. This was proven by an Oklahoma-based Emergency Physicians Billing Services (EPBS). They were sued by the government for improper coding. The suit involved over 100 emergency departments in 33 states using the service. After being tipped off by a whistleblower, the Department of Justice found that EPBS was billing at levels consistently higher than the national average—the billing company billed disproportionately higher numbers of level 5 codes and used levels 1 and 2 less. Court testimony revealed internal company policy that instructed coders to limit their use of levels 1 and 2.
The company and all the practices it serviced were held liable under the *False Claims Act.*[^1] EPBS paid $15 million to resolve the allegations. Client medical practices each paid fines ranging from $50,000 to $8,000,000.[^1] In addition, EPBS entered into a Corporate Integrity Agreement.

**Purpose:**

Frequent audit triggers are the 99214 and 99215 codes.[^1] The federal agents are looking for instances where medical necessity doesn’t justify the code.[^4] Specifically, they are looking for visits that are made to look more complex than they really are.[^1] Typically, Medicare carrier auditors or federal agents will audit 20-30 charts and generate an error rate.[^1] This study will generate an error rate from approximately 40 chart notes. Not only will an error rate be determined but also the extent of financial damages incurred on a typical day as a result. After an exhaustive literature search, I found there are no easily accessible studies looking at the error rate in a typical small family practice setting. There are also no studies that give any insight as to how to correct these problems. This study will try to determine how often coding errors occur and what areas need to be improved.

**Significance:**

Improper coding is becoming a priority for the Centers for Medicare and Medicaid Services (CMS). In 2003, CMS produced its first Improper Medicare Fee-For-Service (FFS) payments report.[^5] CMS has established two programs to monitor the accuracy of Medicare FFS: The Comprehensive Error Rate Testing (CERT) program and the Hospital Payment Monitoring Program (HPMP).[^5] The CERT contractor calculates the error rate for claims submitted to Carriers, Durable Medical Equipment, Regional Carriers, and Fiscal Intermediaries.[^7] Since the inception of the CERT Program, CMS and its contractors have focused on reducing the errors in

[^1]: E.g. EPBS, 11
[^4]: E.g. Medicare, 11
[^5]: E.g. FFS, 5
[^7]: E.g. CERT, 7

the billing, payment, and/or processing of Medicare claims. Efforts also need to be made on a personal level to ensure proper coding is taking place. By determining if improper coding is occurring on a regular basis, education and insight can be gained as to why these mistakes are being made. This study will look for the simple adjustments that can be made to avoid coding errors. It will also help determine if these innocent errors are resulting in significant financial liability for the practice.

Design of the Study

Research Question:

What is the frequency of improper E&M coding in a family practice setting, particularly down-coding and what are the financial losses incurred as a result?

Assumptions:

I believe improper coding occurs on a regular basis, whether it is deliberately or as the result of misunderstanding of the specifics of the coding requirements. Coding is difficult subject material. Mistakes are being made and not being fully resolved until audits occur. Audit fines can be avoided with proper documentation and an understanding of basic coding knowledge. I believe this study will show the frequency of improper coding and will show higher rates of down-coding as oppose to up-coding.

Scope and Limitations:

This project will review 10 chart notes from 4 providers all of the same family practice. The providers consist of two D.O.s, one M.D., and one Nurse Practitioner. All of these providers have made a conscious effort to further educate themselves in regards to coding. They have watched videos, attended workshops, and have notes near their desk reminding them of proper
documentation. Which means, this office may have a better grasp of coding that other offices.

The results from this study include documentation from only one office. This will make it difficult to assume other offices have similar coding errors.

**Research Design:**

This study was a retrospective chart review. Four providers from the same family practice volunteered to have their charts systematically reviewed from the first working day in May of 2005. Ten chart notes per provider were evaluated. The most recent chart note was used, totaling forty chart notes of established patients. The project did not include chart notes involving children, pregnant women, new patients, or anyone else deemed a susceptible population.

The chart note was compared with the billed E&M code, using a program called *Stat Coder* as my measurement tool. This allowed for all the chart notes to be reviewed in the same fashion with an unbiased view. *Stat Coder* determines the correct E&M code. The E&M code provided by *Stat Coder* was compared to the code billed out at the time of service. This data was compiled to determine the frequency of improper coding and the losses incurred as a result. Dr. Morgan Ford supervised this project in his clinic, Post Falls Family Medicine. Questions during the project were directed to him and Trish Ortega, who is a certified professional coder.

**Results:**

After a chart review of forty notes, the frequency of incorrect coding occurred at a rate of 55%. Correct coding occurred 45% of the time. Incorrect coding was split into two categories: up-coding and down-coding. Up-coding occurred 37.5% as an overall occurrence and accounted for 68% of the chart notes that were coded incorrectly. Down-coding occurred at a rate of 17.5% overall and accounted for 32% of the chart notes that were coded incorrectly. This has led to the conclusion that improper coding occurs more than half of the time and the tendency to up-code
rather than down-code is more prevalent. The codes used most frequently were the 99213 code, occurring 80% of the time. The 99214 code was used 15% of the time and the 99212 code was used 5% of the time. Codes 99215 and 99211 were never used. Improper codes were never more than one off, meaning if it should have been a 99214, than it was billed as a 99213 and not a 99212. Two hundred and twenty seven dollars was lost due to down-coding, whereas, up-coding resulted in over billing three hundred and thirty two dollars. If you assume there are 260 working days in a year and if this happens daily, than $59,020 was lost and $86,320 was over-billed. It is important to note there is a difference in cost for each code and these costs vary from office to office, region to region, and are determined in part by the RBRVS. This study was limited by its small scale and a larger chart review, including more offices could give different results. However, due to time constraints it was not possible to make this study any larger.

Discussion:

This small scale research project concluded that improper coding occurs at an excessive rate and the tendency to up-code is stronger than the tendency to down-code. This is a problem that needs to be corrected from a legal standpoint and a financial standpoint. The question as to why improper coding occurs, needs to be answered next. In most cases, the trend was a physical exam that was well documented, but a history that was not always reflective of the billed code. This was the most common mistake and was found mostly during follow-up visits. This can be corrected by stating any changes in the status of the condition, documenting a more thorough review of systems and documenting the past family and social history.

If time had permitted, I would have also liked to identify specifically what changes needed to be made to allow for the code being used. This would have expanded the data section and allowed to reader to see what areas of documentation were lacking with more specific
examples. In addition, I think it is important to learn more about what kind of training the four providers had in regards to coding and billing. Is most of their knowledge learned on the job? What percent of their time is spent learning more about coding? How many clinics do they attend annually that focus on coding basics? Where did they learn their base coding knowledge, was it in medical school, on the job, or through private workshops and the help of a professional coder? Answering these questions, would have given insight as to maybe why the errors are occurring. For example one could argue the errors occur secondary to poor preparation during medical school to deal with the complex methodology of assigning a code.

Conclusions and Recommendations:

Coding is a very difficult subject. As a provider, it is important to build a foundation of knowledge and use that knowledge daily as a way of decreasing coding errors. Coding errors can be costly, either as a result of lawsuits or a result of getting underpaid for services provided. It is recommended that the provider continues to expand and improve their coding knowledge through whatever educational resources are available, such as books, classes, and videos.

The American Academy of Family Physicians (AAFP) suggests the following to prevent fraud and abuse problems if they arise:

1. If you need advice on coding, documentation or managing Medicare claims in your practice, do not call your carrier. This only draws unwanted attention to you. Specialty societies like the AAFP are a better, safer source of guidance.
2. Evaluate characteristics of your practice that are likely to place you at higher risk of fraud and abuse, and focus your attention there first.
3. Develop systems to monitor your documentation and claims before you submit them.
4. Develop educational programs for both physicians and office staff involved in documenting services and submitting claims. But remember to seek the biggest bang for you buck. No practice can manage all its potential liabilities at once. Prioritization is important.
5. Develop accurate documentation aids, such as history and physical exam forms and lists of encounter characteristics that support the use of certain codes. Then periodically compare your claims with their supporting documentation as a early warning system.
6. Read all communications from third-party payers about their billing requirements and make sure all physicians are aware of their contents.

7. Examine carefully any billing company contract to ensure that it requires the company to stay informed of evolving Medicare rules and affirmatively notify its customer of changes. Any billing company contract should be reviewed carefully with legal counsel.

8. With the protection of attorney-client privilege, investigate any situation you suspect may represent fraud and abuse. An internal audit conducted by experienced Medicare consultants under the aegis of a lawyer can be useful.

Specifically, I found from the research study that the easiest area to improve was better documentation of the history of present illness. If the documentation of history of present illness was more thorough, many of the improper codes could easily be corrected. Specifically, if it is a new problem, focus should be given to the onset, location, duration, characteristic, aggravators, relievers, treatments tried, and associated factors. It should also be documented “all other review of systems are negative” if this is the case. This shows they were reviewed and is an essential part of choosing the correct code. But the most important thing to remember is coding takes practice and to become a master it needs to be thought about and applied daily. I would also recommend educational institutions focus on were coding knowledge is lacking a take responsibility for teaching coding to their students.
## Table I: Data Collection

<table>
<thead>
<tr>
<th>Chart #</th>
<th>Original Coding</th>
<th>Coding per Project Analysis</th>
<th>Down-coded</th>
<th>Correctly Coded</th>
<th>Up-coded</th>
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Table II: Amount billed according to code
## Table III: The Three Key Component Coding Guidelines—Established Patient Encounters

### Key Component #1 - History

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<thead>
<tr>
<th>Abrev.</th>
<th>Documentation Item</th>
<th>99212 Focused</th>
<th>99213 Expanded</th>
<th>99214 Detail</th>
<th>99215 Comprehensive</th>
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</thead>
<tbody>
<tr>
<td>CC</td>
<td>Chief Complaint</td>
<td>X</td>
<td>X</td>
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<tr>
<td>HPI</td>
<td>History of Present Illness</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>ROS</td>
<td>Review of Systems</td>
<td></td>
<td>X</td>
<td>X</td>
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</tr>
<tr>
<td>PMHx</td>
<td>Past Medical History</td>
<td></td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>PFHx</td>
<td>Past Family History</td>
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<td>X</td>
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</tr>
<tr>
<td>PSHx</td>
<td>Past Social History</td>
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### Key Component #2 - Examination

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<th>99213 Expanded</th>
<th>99214 Detail</th>
<th>99215 Comprehensive</th>
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</thead>
<tbody>
<tr>
<td>Exam</td>
<td>How many bullets in what systems?</td>
<td>1 System or 1-5 elements</td>
<td>2 Systems or 6-11 elements</td>
<td>5-7 Systems or 12 elements</td>
<td>8+ Systems or 18 elements</td>
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### Key Component #3 - Medical Decision Making

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<tr>
<th>Abrev.</th>
<th>Documentation Item</th>
<th>99212 Focused</th>
<th>99213 Expanded</th>
<th>99214 Detail</th>
<th>99215 Comprehensive</th>
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<tr>
<td>MDM</td>
<td>Medical Decision Making</td>
<td>Straight-forward</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
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<td>Table IV: Physical Exam Elements</td>
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<tr>
<td><strong>Constitutional</strong></td>
<td><strong>General Appearance</strong></td>
<td><strong>GU</strong></td>
<td><strong>MALES</strong></td>
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<tr>
<td>• Conjointiva and lids</td>
<td>• Scrotum</td>
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<tr>
<td><strong>Eyes</strong></td>
<td>• Pupils and irises</td>
<td>• Penis</td>
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<tr>
<td>• Ophthalmoscopic exam</td>
<td>• Digital Rectal Exam</td>
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<tr>
<td><strong>ENT</strong></td>
<td>• Ears and Nose (External)</td>
<td>• External genitalia/vagina</td>
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<tr>
<td>• Otoscopic Exam</td>
<td>• Urethra</td>
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<td>• Hearing</td>
<td>• Bladder</td>
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<tr>
<td>• Nasal mucosa, septum, turbinates</td>
<td>• Cervix</td>
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<tr>
<td>• Lips, teeth, gums</td>
<td>• Uterus</td>
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<tr>
<td>• Oropharynx</td>
<td>• Adnexa/Parametria</td>
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<td><strong>Neck</strong></td>
<td>• Neck Exam (Masses)</td>
<td>• Gait/Station</td>
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<td>• Thyroid Exam</td>
<td>• Musculoskeletal</td>
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<tr>
<td><strong>Respiratory</strong></td>
<td>• Respiratory Effort</td>
<td>• Digits/Nails</td>
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<td>• Percussion of Chest</td>
<td>• Palpation of Chest</td>
<td>• Inspection/Palpation</td>
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<tr>
<td>• Palpation of Chest</td>
<td>• Auscultation of Chest</td>
<td>• Range of Motion</td>
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<tr>
<td>• Auscultation of Chest</td>
<td>• Stability</td>
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<tr>
<td>• Carotid Arteries</td>
<td>• Muscle</td>
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<tr>
<td>• Abdominal Aorta</td>
<td>• Strength/Tone</td>
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<td>• Femoral Arteries</td>
<td>• Palpation</td>
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<td>• Pedal Pulses</td>
<td>• Cranial Nerves</td>
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<td>• Extremities (Edema)</td>
<td>• Deep Tendon Reflexes</td>
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<td>• Inspection Psychiatric</td>
<td>• Sensation</td>
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<tr>
<td>• Palpation (w/axillae)</td>
<td>• Orientation x 3</td>
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<td><strong>Abdomen</strong></td>
<td>• Memory</td>
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<tr>
<td>• Exam &amp; Note mass/tenderness</td>
<td>• Mood and Affect</td>
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<tr>
<td>• Liver and spleen</td>
<td>• Judgment and insight</td>
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<td>• Hernias Lymphatic</td>
<td>• Palpation of 2 or more areas:</td>
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<tr>
<td>• Anus, rectum, perineum</td>
<td>• Neck, axillae, groin, or other</td>
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<td>Table V: Medical Decision-Making</td>
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<td><strong>Diagnostic/Treatment Options</strong></td>
<td><strong>Data</strong></td>
<td><strong>Risk</strong></td>
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<tr>
<td>Straightforward 99212</td>
<td>1 minor problem</td>
<td>Lab tests (venous), simple radiology, EKG</td>
<td>Minimal treatment, refill meds</td>
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<td>Low Complexity 99213</td>
<td>2 minor problems, 1 stable chronic, acute uncomplicated illness/injury</td>
<td>Physiologic test w/o stress, lab tests (arterial), superficial biopsies, contrast studies (non-cardiac)</td>
<td>PT, OTC drugs</td>
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<td>Moderate Complexity 99214</td>
<td>1 chronic with mild exacerbation, 2 stable chronic, acute illness with systemic symptoms, new condition with uncertain prognosis</td>
<td>Physiologic test with stress, deep biopsies, invasive testing w/o risk factors</td>
<td>Prescription drug management (add, change, or remove medicine)</td>
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<td>High Complexity 99215</td>
<td>Chronic illness w/ severe exacerbation that pose a threat to life or bodily function, acute change in neurologic status</td>
<td>Invasive testing w/risk factors</td>
<td>Drug therapy w/monitoring</td>
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Figures

Figure I: Frequency of coding errors

- Overcoded: 45%
- Undercoded: 17.5%
- No Change: 37.5%

Figure II: Chart notes coded correctly vs. incorrectly?

- Incorrect: 22
- Correct: 18
Table III: How often were certain codes used originally?

Table IV: Financial Consequences
References


