Coding, Compliance and updates for the practicing Allergist for 2013

Presented by
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I have no disclosure to report
Disclosure information

- No relevant relationships disclosed
Topics for Discussion

- 2013 Updates for CPT Codes
- Audits – Private payer and government payers
- Incident to review
- Documentation guidelines
- Diagnosis Coding
- E/M Coding
Subsection Heading for Allergy and Clinical Immunology

“.....which may include new or established patient office or other outpatient services (99201-99215), hospital observation services (99217-99220, 99224-99226), hospital care (99221-99233) consultations (99241—99255), emergency department services (99281-99285) nursing facility services (99304-99318), domiciliary, rest home or custodial care services (99324-99337), home services (99381-99429) should be reported using modifier 25.”
2013 CPT Changes

- Allergy testing Code Changes
- (For administration of medications (eg, epinephrine, steroidal agents, antihistamines) for therapy for severe or intractable allergic reactions, use 96372)
- 95004 – Percutaneous tests (scratch, puncture, prick) with allergenic extracts, immediate type reaction, including test interpretation and report by a physician, specify number of tests (deleted “by a physician”)
2013 CPT Changes

- 95010 and 95015 – deleted
- 95017 – Allergy testing, any combination of percutaneous (scratch, puncture, prick) and intracutaneous (intradermal) sequential and incremental, with venoms, immediate type reaction, including test interpretation and report. Specify number of tests
- RVU value 2.52
2013 CPT Changes

- 95018 Allergy testing, any combination of percutaneous (scratch, puncture, prick) and intracutaneous (intradermal) sequential and incremental with drugs or biologicals, immediate type reaction, including test interpretation and report, specify number of test.

- RVU value .86
2013 CPT Changes

- 95024, 95027 – Deleted the wording “by a physician.”
- New subsection – Ingestion Challenge Testing
New Subsection – Ingestion Challenge Testing

- Codes 95076 and 95079 are used to report ingestion challenge testing. Report 95076 for initial 120 minutes of testing time (i.e., not physician face to face time). Report 95079 for each additional 60 minutes of testing time ...

- For total time less than 61 minutes (e.g., positive challenge resulting in cessation of testing). Report an evaluation and management service if appropriate.
Ingestion Challenge Testing

- Patient assessment/monitoring activities for allergic reaction are not separately reported. Intervention therapy (e.g., injection of steroid or epinephrine) may be reported separately as appropriate.

- For purposes of reporting testing times, if an E/M service is required, then testing time ends.
2013 CPT Changes

- 95076 – Ingestion challenge test (sequential and incremental ingestion of test items, eg, food, drug or other substance); initial 120 minutes – RVU value 3.42

- +95079 – each additional 60 minutes of testing RVU value 2.41

- Time will need to be documented in the testing document to support the coding
2013 CPT Changes

- 95120 – 95134 – added “in the office or institution of the prescribing physician or other qualified health care professional” including allergenic extract:.....
2013 CPT Changes

- Pulmonary Coding Changes

- Subsection instruction changes – same as allergy section for definition for E/M billing in addition to pulmonary billing

- 94014, 94016 added ‘‘physician or other qualified health care professional” to the code description.
2013 CPT Changes

- Miscellaneous Code changes
- 99000, 99001 – Handling and/or conveyance of specimen for transfer from the office to a laboratory.....delete “physician”
2013 CPT Changes – Evaluation and Management Codes

Definition of a new or established patient:

- Added the phrase “other qualified health care professional who may report evaluation and management services reported by a specific CPT Code”
Evaluation and Management Codes

- Add to paragraph:
  - “In the instance where a physician/qualified health care professional is on call for or covering for another physician/qualified health care professional, the patient encounter will be classified as it would have been by the physician qualified health care professional who is not available. When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and exact same subspecialties as the physician.”
2013 CPT Changes

- Evaluation and management Code Changes
  - Added the phrase “other qualified health care professionals to all code descriptions"
2013 CPT Changes

- Category II CPT Code changes
- 3750F Patient not receiving dose of corticosteroids greater than or equal to 10mg/day for 60 or greater consecutive days
2013 Evaluation & Management Codes

- New Codes for 2013
- Chronic Care coordination Services
- 99487- 99489
2013 E/M Codes – 99487-99489
(Bundled by CMS Fee Schedule status)

- 99487-99489 includes:
  - Communication (with patient, family members, guardian or caretaker, surrogate decision makers, and/or other professionals regarding aspects of care)
  - Communication with home health agencies other community services utilized by the patient
  - Collection of health outcomes data and registry documentation
  - Patient and/or family/caretaker education to support self management, independent living, and activities of daily living
Assessment and support for treatment regimen adherence and medication management

Identification of available community and health resources

Facilitating access to care and services needed by the patient and/or family

Development and maintenance of a comprehensive care plan
2013 E/M Codes 99495-99496
Transitional Care Management Services

- Requires face to face encounter, initial patient contact and medication reconciliation within specific time frames. TCM requires an interactive contact with the patient or caregiver, as appropriate, within two business days of discharge. May be direct, telephonic, or by electronic means. Medication reconciliation and management must occur no later than the date of the face to face visit.
2013 E/M Codes 99495-99496

Transitional Care Management Services

99495 – Transitional Care Management Services

- Communication with the patient and/or caregiver within 2 business days of discharge
- Medication decision making of at least moderate complexity during the service period
- Face-to-face visit, within 14 calendar days of discharge

99496 – Transitional care management services

- Communication with patient – 2 business days
- Medical decision making of high complexity
- Face to face visit, within 7 calendar days of discharge
Medicare
Medicare - 2013

- Conversion factor will stay the same for 2013 as it was in 2012 – at least at this point
- E-Prescribing is required or a 1.5% deduct on Medicare reimbursement
- PQRS requires starting to report in 2013
- 2015 there will be a deduct for not participating in PQRS
- Phase II of Meaningful use is implemented
Medicare 2013 – POS clarification

When face-to-face services are provided for a patient who is not a registered inpatient or outpatient, the POS code should match the setting in which the beneficiary received the face-to-face service.

4. When there is no face-to-face service (e.g., the physician provides interpretation of a diagnostic test, only), the POS is that in which the beneficiary received the technical component (TC) of the service.
Medicare 2013 POS Clarification

**CMS example:** The patient receives an MRI at an outpatient hospital near his/her home. The hospital submits a claim for the TC portion of the MRI. A physician performs the professional portion of the beneficiary’s MRI (i.e., the interpretation) in his office. In this case, the POS for the physician service is the outpatient hospital (POS 22)—even though the interpretation occurred in the physician office—because that is where the patient received the face-to-face portion of the MRI.
Medicare 2013 – as of Jan 2, 2013

- Turns off the Jan. 2, 2013, sequester for two months. This prevents various defense and other automatic cuts from occurring, including an across the board, two percent cut for all Medicare providers. It's expected Congress will revisit issues related to the sequester in the near future.

- Extends the Medicare 1.0 work RVU GPCI floor through Dec. 31, 2013.
Medicare -2013

- Increases the Medicare Part B equipment utilization assumption for advanced imaging services to 90 percent effective for fee schedules established for 2014 and subsequent years, thus reducing future payments.
- Extends the Medicare therapy cap exception process through Dec. 31, 2013.
- Increases the Medicare therapy service multiple procedure payment reduction from 25 to 50 percent effective April 1, 2013.
PQRS

- Must start reporting in 2013 to avoid a penalty in 2015
- 2013 .5% incentive
- Requires both NPI and Tax ID #
- Pay-for-reporting, not pay-for-performance
- Initially required CPT II or “G” codes along with billing codes on claims; now there are four ways to participate
- Registry participation is the most promising path for small- and medium-sized practices
- PQRS is not a substitute for local quality improvement efforts
PQRS Reporting methods

- Medicare Part B claims-based reporting (CPT II or G codes)
- Reporting to a CMS-approved registry (PQRIWizard is one option)
- Via qualified electronic health record product
- EHR data reporting through a qualified Physician Quality Reporting data submission vendor
PQRS

- Measure group reporting via claims or registry
- G8645: I intend to report the Asthma Care Measures Group
- Measures Group Reporting via Registry-only
- G8900: I intend to report the Sleep Apnea Measures Group
Measures reporting requirements

- 20 Patient Sample Method via claims – 12-month reporting period only:

- For claims-based submissions, a participating eligible professional must report on all applicable measures within the selected measures group when billing measure-eligible claims for a minimum sample of 20 unique Medicare Part B FFS patients who meet patient sample criteria for the measures group (include Medicare Secondary Payer)

- For claims-based submissions, the measures group-specific intent G-code must be submitted once during the reporting period to indicate the eligible professional’s selection of the measures group.
Measures reporting requirements

- **20 Patient Sample Method via registry** – 12-month or 6-month reporting period:

- For registry-based submissions, a participating eligible professional must report on all applicable measures within the selected measures group for a minimum sample of 20 unique patients, a majority of which must be Medicare Part B FFS patients, who meet patient sample criteria for the measures group. If the eligible professional does not have at least 11 unique Medicare Part B FFS patients who meet patient sample criteria for the measures group, the eligible professional will need to choose another measures group or choose another reporting option.
Measures reporting requirements

- Asthma: Pharmacologic Therapy for Persistent Asthma - Ambulatory Care Setting
- Asthma: Assessment of Asthma Control - Ambulatory Care Setting
- Asthma: Tobacco Use: Screening - Ambulatory Care Setting
- Asthma: Tobacco Use: Intervention - Ambulatory Care Setting
Measure reporting requirements
Sleep Apnea Measures Group
(only reportable through Registry)

- **Sleep Apnea Measures Group Overview**

- 276 Sleep Apnea: Assessment of Sleep Symptoms
- 277 Sleep Apnea: Severity Assessment at Initial Diagnosis
- 278 Sleep Apnea: Positive Airway Pressure Therapy Prescribed
- 279 Sleep Apnea: Assessment of Adherence to Positive
AUDITS
Allergy practices and Audits

- Number of Test performed
- Number of Doses charged
- Medical Necessity for allergy testing and an E/M on the same calendar date
- Incident to services with mid levels
Incident To Guidelines

- Applicable to ALL government entities – medicare, medicaid, Champus, Federal employees ----

- Incident to - physician has established a plan of care for an employee to follow.
  - Physician must be on site when the service is provided
  - NP, PA may not supervise diagnostic test under incident to guidelines and bill the service under the physician.
OIG Work plan for 2012-2013

1. Non-compliance with assignment guidelines
2. Incident to services
3. Place of Service errors
4. Evaluation and Management codes based on 2010 payments
5. E/M with modifiers
6. Claims with G modifiers
7. Payments for physician administered drugs and biologics
8. Medicare as a secondary payer
RAC Reviews and Audits

- RAC scope includes pre-payment fraud, waste and abuse efforts not limited to credit balance audits, incorrect billing and processing errors, and lack of medical necessity.

- Post payment RAC work includes data mining, medical records review, identifying overpayments.
RAC Reviews and Audits – Connelly Consulting

- Incorrect billing of Evaluation and Management Claims
- Physician Evaluation and Management Services During Same Day Global Period
- Place of Service Errors for Physician claims for service performed in an ASC or outpatient Hospital
- Place of Service Errors for Physician claims for service performed in Hospital Inpatient setting
- Duplicate Claims - Physician (Carrier) CMS
- Modifier 59 – Know when you can use it appropriately
- Excessive Units - Untimed Codes
RAC and other payer audits

- Focusing on allergy doses and testing
- E/M on the same date as a testing –
- Some allergists have been reviewed back for three years from Medicaid or Medicare.
- Blue Cross in some states has reviewed most all allergists for E/M on the same day.
- United is not paying in some states for E/M and testing on the same date unless notes are submitted.
# Allergist Coding Curve

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<thead>
<tr>
<th>National</th>
<th>National</th>
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<tbody>
<tr>
<td>99201</td>
<td>.47%</td>
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<tr>
<td>99202</td>
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<td>30.42%</td>
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<tr>
<td>99244</td>
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<tr>
<td>99245</td>
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</table>
ALLERGIST CODING CURVE

- National
- 99211 3.98%
- 99212 6.77%
- 99213 55.25%
- 99214 31.09%
- 99215 2.91%
Audit Response

- Know your risk
- Seek counsel if you are high risk
- Review your records
- Have a third set of unbiased eyes read the notes
- Respond in a timely manner
- Communicate with the payer performing the review.
- Negotiate
NUTS AND BOLTS OF CODING FOR AN ALLERGY PRACTICE


Diagnosis Coding

- The diagnoses need to be specific – ICD-10 is here in 2014
- Remember place the diagnosis with the most acuity first
- Acute precedes chronic
- Co-morbidities – you need to address how the comorbidity affect the allergy/asthma issues
- List the co-morbidities after your dx
- If you code it make sure it is in the documentation
- Medical necessity is defined with diagnosis codes
Chart Auditing – How to analyze your chart notes

- Chief Complaint – make sure your note leads the reader down the appropriate path
- CC – “Patient is here for retesting for allergies”
- HPI – Make sure your HPI is for today’s encounter.
- HPI – Make sure it is clear what information is for today. Previous information is ok but only for your information.
- HPI – The provider is required to obtain the information for the HPI.
• Past, family and social history – make sure it is applicable to the patient for your questions.

• ROS – if the patient is filling out the information or your staff, make sure there is documentation to support the providers review of the information obtained.
Chart Auditing – How to analyze your chart notes

- Exam – 2013 tell the reader what you see
- Normal is ok but describe – templates
- Make sure templates match the rest of the note for complaints
- You may use either the allergy specific or the general medical exam (1995 or 1997 guidelines)
Difference between a 99204 and a 99205

- 99204
- 99205
- Comprehensive hx
- Comprehensive exam
- Moderate medical decision making
- High medical decision making
Moderate Medical Decision making
(need two at same level or higher)

- Number of Diagnosis 3 or more
- Amount of Data 3 or more
  - Lab
  - Radiographs
  - Medical records
  - Medicine tests not billed
- Risk
  - Moderate: Prescription drug management, undiagnosed new problem, one or more chronic conditions with mild exacerbation, progression or side effects of treatment
High Medical Decision Making need two at the same level or higher

- **Number of diagnosis** 4 or more
- **Amount of data** 4 or more
- **Risk**
  - **High:**
    - Drug therapy requiring intensive monitoring for toxicity
    - One or more chronic illness with severe exacerbation, progression or side effects of treatment
    - Acute or chronic illness or injuries that pose a threat to life or bodily function
Ancillary services

- Allergy testing
  - Interpret the test because the code includes interpretation and report as part of the code.
  - Have name and/or initials of the supervising provider on the test
- Nebulizer treatments, MDI instruction
  - Separate document
- CT Scans, radiographs
  - If billing for it as a separate service, there should be a report as a separate document in the chart.
- Scopes
  - Separate procedure note
Ancillary Services

- Immunotherapy – make sure billings for CMS are per cc – limit per billing are 10 cc’s.
- Make sure there is documentation of the “recipes” for each patient.
- Document on the allergy injection record the beginning of a new vial.
- Document review of allergy injection record.
- If more than “normal” number of injections, make sure medical record supports the necessity of the higher number of vials manufactured.
Medical decision cheat sheet 99213

1. Two diagnosis doing well on RX – allergic rhinitis and asthma; allergic rhinitis and conjunctivitis

2. One diagnosis worse on RX – dermatitis not responding
Medical Decision making cheat sheet 99214

- Three diagnosis doing well – allergic rhinitis, asthma, anaphalasis to foods; or allergic rhinitis, asthma, dermatitis
- One new problem requiring an RX - urticaria requiring a RX
- One diagnosis doing well and one diagnosis not responding or worse. Both diagnoses are RX treatment – allergic rhinitis worse, asthma stable
New problem – pt acutely ill and needs labs, radiology studies, review of chart notes consultation with another health care provider. OR pt presents with additional workup planned and is high risk –
Time

- Time is appropriate if more than 50% is counseling and coordination or care
- Document total face to face time
- Percentage is greater than 50% of the encounter
- Document the discussion with the patient.
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### HISTORY

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### REVIEW OF SYSTEMS

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### FAMILY HX

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### SOCIAL HX

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### EXAM

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### 1 organ sys | 2-4 organ sys | 5-7 organ sys | 8 organ systems | 8 organ systems |

### MED. DEC MAKING

- **MGMT OPT. & DX**: Minimal (1) - Limited (2) - Multiple (3) - Extensive (4+)
- **AMT DATA & COMPLEX**: Minimal (1) - Limited (2) - Moderate (3) - Extensive (4+)
- **RISK OF COMPLICAT**: Minimal - Low - Moderate - High

(2 of the 3 must be met or exceeded)
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</table>
After completing the table which describes the history, circle the type of history within the appropriate grid in Section 5.

### HPI (history of present illness) elements:

<table>
<thead>
<tr>
<th>Location</th>
<th>Severity</th>
<th>Timing</th>
<th>Modifying factors</th>
<th>Associated signs and symptoms</th>
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<tbody>
<tr>
<td>ROS (review of systems):</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Constitutional (wt, loss, etc.)</td>
<td>2. GI</td>
<td>3. Integumentary (skin, breast)</td>
<td>4. Endo</td>
<td></td>
</tr>
</tbody>
</table>

### PFSH (past medical, family, social history) areas:

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

Complete PFSH:
- For 2 areas: a) Establish pts, office (outpt) care, b) Emergency dept, c) Subseq nursing facility care
- For 3 areas: a) New pts, office (outpt) care, domiciliary care, b) Consultations, c) Initial hospital care, d) Hospital observation, e) Comprehensive nursing facility assessments.

10 or more systems, or some systems with statement "all others negative".

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### 2. Examination

Refer to data section (table below) in order to quantify. After referring to data, identify the type of examination. Circle the type of examination within the appropriate grid in Section 5.

<table>
<thead>
<tr>
<th>Affected body area or organ system (one body area or system related to problem)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limited to affected body area or organ system (one body area or system related to problem)</td>
</tr>
<tr>
<td>Affected body area or organ system and other symptomatic or related organ system(s) (additional systems up to total of 7)</td>
</tr>
<tr>
<td>General multi-system exam (8 or more systems) or complete exam of a single organ system (complete single system exam not defined in these instructions)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Head, including face, chest, including each extremity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sinus, including nose, mouth, throat</td>
</tr>
<tr>
<td>Eyes</td>
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</table>

<table>
<thead>
<tr>
<th>Organ Systems:</th>
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<tbody>
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<td>Constitutional (e.g., vitals, gen app)</td>
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<td>Cardiovascular</td>
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<table>
<thead>
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<th>Up to 7 systems</th>
<th>8 or more systems</th>
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<td>Problem Focused Exam</td>
<td>Exp. Prob. Focused</td>
<td>Detailed Exam</td>
<td>Comprehensive Exam</td>
</tr>
<tr>
<td>Level of Complexity</td>
<td>Presenting Problem(s)</td>
<td>Diagnostic Procedure(s)</td>
<td>Management Options</td>
</tr>
<tr>
<td>---------------------</td>
<td>-----------------------</td>
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<td>--------------------</td>
</tr>
<tr>
<td>Minimal/ Straight-forward</td>
<td>Self-limited or minor problem, e.g., cold, insect bite, tonsillitis</td>
<td>Laboratory tests requiring venipuncture, Chest x-rays, EKG/EEG, Urinalysis, Ultrasound, e.g., echo, KOH prep</td>
<td>Chest x-rays, EKG/EEG, Urinalysis, Ultrasound, e.g., echo, KOH prep</td>
</tr>
<tr>
<td>Low Complexity</td>
<td>Two or more self-limited or minor problems, e.g., stable chronic illness, well controlled hypertension or non-insulin dependent diabetes, catarrh, BPH, acute uncomplicated illness or injury, e.g., cystitis, allergic rhinitis, simple sprain</td>
<td>Physiologic tests not under stress, e.g., pulmonary function tests, Non-cardiovascular imaging studies with contrast, e.g., barium enema, Clinical laboratory tests requiring arterial puncture, Skin biopsies</td>
<td>Rest, Gargles, Elastic bandages, superficial dressings</td>
</tr>
<tr>
<td>Moderate Complexity</td>
<td>One or more chronic illness with mild exacerbation, progression, or side effects of treatment, Two or more stable chronic illnesses undiagnosed new problem with uncertain prognosis, e.g., lump in breast, Acute illness with systemic symptoms, e.g., pyelonephritis, pneumonitis, colitis, Acute complicated injury, e.g., head injury with brief loss of consciousness</td>
<td>Physiologic tests under stress, e.g., cardiac stress test, fetal contraction stress test, Diagnostic endoscopies with no identified risk factors, Deep needle or incisional biopsy, Cardiovascular imaging studies with contrast and no identified risk factors, e.g., arteriogram, cardiac catheterization</td>
<td>Over the counter drugs, Minor surgery with no identified risk factors, Prescription drug management, Therapeutic nuclear medicine, IV fluids with additives, Morbidity low/full recovery expected</td>
</tr>
<tr>
<td>High Complexity</td>
<td>One or more chronic illness with severe exacerbation, progression, or side effects of treatment, Acute or chronic illnesses or injuries that pose a threat to life or bodily function, e.g., multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure</td>
<td>Cardiovascular imaging studies with contrast, Cardiac electrophysiologic tests, Diagnostic endoscopies with identified risk factors</td>
<td>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, High morbidity/mortality without treatment, Prolonged functional impairment possible</td>
</tr>
</tbody>
</table>

**Final Result for Complexity**

Draw a line down any column with 2 or 3 circles to identify the type of decision making in that column. Otherwise, draw a line down the column with the 2nd circle from the left.

<table>
<thead>
<tr>
<th>A Number diagnoses or treatment options</th>
<th>B Amount &amp; complexity of data</th>
<th>C Highest Risk</th>
<th>Type of Decision Making</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 1 Minimal</td>
<td>1 Minimal</td>
<td>Minimal</td>
<td>STRAIGHT</td>
</tr>
<tr>
<td>2 Limited</td>
<td>2 Moderate</td>
<td>Low</td>
<td>LOW</td>
</tr>
<tr>
<td>3 Multiple</td>
<td>3 Moderate</td>
<td>Moderate</td>
<td>MODERATE</td>
</tr>
<tr>
<td>4 Extensive</td>
<td>4 High</td>
<td>High</td>
<td>HIGH</td>
</tr>
</tbody>
</table>
Questions???

- Thank you,