

Risk Based E&M Coding Worksheet

(Worksheet developed by suggestions from speaker evaluation form,
please fill out *YOUR* evaluation form to improve presentations!)

1. RISK

**If your patient has.... If you are going to order.... If the patient will need....
(high risk)**

- acute or chronic illnesses or injury that pose a threat to life or bodily function
 - diagnostic endoscopies with identified risk factors
 - emergency major surgery (open, percutaneous, or endoscopic)

(moderate risk)

- undiagnosed new problem with uncertain prognosis, e.g. lump in breast
 - diagnostic endoscopies with no identified risk factors
 - elective major surgery with no identified risk factors
 - prescription drug management

(low risk)

- one stable chronic illness, e.g. well controlled hypertension or non-insulin dependent diabetes, cataract, BPH
 - non-cardiovascular imaging studies with contrast, e.g. barium enema
 - occupational therapy
 - IV fluids without additives

(minimal risk)

- one self-limited or minor problems, e.g. cold, insect bite, tinea corporis
 - laboratory tests requiring venipuncture
 - rest
 - gargle

Risk = _____ level

2. DATA (Audit points)

1 point per category, ordered/reviewed--Clinical lab(s), x-ray(s); decision to obtain old records; direct visualization/interpretation of study; medical diagnostic test(s); discussion of unexpected results with perform./interpret. physician.

2 points for review and summary of old record from source other than patient.

Data = _____ points

3. Diagnosis/Mgmt. Options (Audit points)

Self-limiting minor problem (1) (max 2 points)

Each Established problem OK (1) Each Established problem unstable (2)

Each New problem no work-up (3) Each New problem plan work-up (4)

Diagnosis = _____ points

4. Medical Decision Making (lowest of the two highest components yields MDM)

RISK	DATA	DX	MDM
min	1 (min)	1 (min)	Straightforward
low	2 (lim)	2 (lim)	Low
mod	3(mod)	3 (mult)	Moderate
high	4(exten)	4(exten)	High

MDM = _____

5. CPT Codes

MDM is **STRAIGHTFORWARD.....**

CPT // type of Hx/PE required // time in min // RVU designation
(xx no time estab.)

(OV) office visit (new*) 99201 PF 10 r0.45

(ER) ER visit 99281 PF xx r0.33

(DS) Domiciliary, Rest Home (eg Boarding Home) or Custodial Care Services
(new*) 99321 PF xx r0.71
(established) 99331** Hx-PFI or Exam-PF xx r0.60

MDM is **LOW...**

(OV) office visit (estab.) 99213** EPF 15 r0.67

(CNF)Comprehensive Nursing Facility Assessments (new or established) 99301** Hx-DI or Exam-C 30 r1.20

(SH) subsequent hosp.care level 1 subsequent hospital inpatient visit 99231** PFI 15 r0.64

MDM is **MODERATE...**

(OV) office visit (new*) 99204 C 45 r2.00 (estab.) 99214** D 25 r1.10

(CON) consult (office or other outpt.) 99244 C 60 r2.58 (initial inpatient) 99254 C 80 r2.64 (confirmatory) 99274 C xx r1.73
(confirm. add modifier-32 if mandated by the carrier)

(HS) Home Services (new*) 99343 D xx r2.27 99344 C xx r3.03

MDM is **HIGH**

(OV) office visit (estab.) 99215 C **40 r1.77

(IH) initial hospital care level 3 initial hospital inpatient visit 99223 C 70 r2.99

(ER) ER visit 99284 D xx r2.71 99285 C xx r3.06

*How “new” is “new”? CPT states a “new patient” is a “patient who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice within the **past 3 years.**” If, however, you are covering for another physician out of your practice or out of your specialty in your group practice, you use the rule as it would apply to that physician. Medicare will decide on your specialty by carrier designation. You may be the same “specialty” under these rules even though you didn’t think so!

** 2 of 3 rule, for subsequent evaluations, **TWO of the three key components** (history, physical, or MDM) must meet or exceed the requirements.

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“ This is Dr. Hippocrates dictating a H&P/ note **CPT code =** _____ on ...”

6. Documentation Guidelines

Comprehensive

History: Chief Complaint

Extended History of Present Illness (4)

Complete Review of Systems 10 of 14

Pert Past, Family, and Social History: 99215--1 specific item from 2 of Past, Family, Social
All others codes--1 specific from each of Past, Family, Social

Physical: Choose General Multi-System Exam or a System Specific Exam

Document indicated bullet points

(General Multi System Exam two bullet points of 9 body systems/areas)

Detailed

History: Chief Complaint

Extended History of Present Illness (4)

Extended Review of Systems 2-9 of 14

Pertinent Past, Family, Social History 1 specific item from any of the 3

Physical: Choose General Multi-System Exam or a System Specific Exam

Document indicated bullet points

(General Multi System Exam two bullet points 6 body system/areas or 12 points in two or more systems)

(Problem focused PF, Expanded Problem focused EPF, guidelines not delineated for worksheet demonstration purposes)

AMA/HCFA documentation guidelines

Jump through the hoops presented in a dictatable format and produce a maximally coded, audit resistant, diagnosis filled, beautifully documented medical record. Physicians profit from increased legitimate CPT coding, hospitals profit from increased diagnoses documentation, resulting in more CC's for increased DRG reimbursement.

Worksheet Adapted from *Pocket Guide to Clinical Coding* by permission of author

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Inpatient non-post-op subsequent visits:

Patient Name _____ Service /Consult date / / _____ time in and/or out _____

Risk (highest)	min/low	Mod	high
Data 1 ea.—lab, x-ray, med dx test, discuss test, old records, direct eval. test. 2—review/summary	1-2	3	4
Dx/mgt. New+ w/u (4) New no w/u (3) Estab. # unstable x 2 Estab. # stable x 1	Estab. Stable / unstable	New no w/u	New + w/u
MDM	straightforwd/low level 1	Moderate level 2	high level 3

PE/and or Hx. 1-5/ CC, HPI 1-3 6-11/ CC,HPI 1-3, ROS 1 ≥12/CC,HPI≥4, ROS 2-9

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Signature _____

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Examples

45 Y.O. With Breast Mass

67 Y.O. With TIA or Seizure

59 Y.O. COPD on O2 for EGD or Surgery, or Acute ↑ Sx.

74 Y.O. Ch. A-fib on Coumadin With Allergic rhinitis

79 Y.O. With Intertrochanteric fracture

18 Y.O. With Pneumonia

81 Y.O. With Pneumonia

19 Y.O. With Presumptive Appendicitis

58 Y.O. With Stable Chronic HTN and NIDDM

1. Risk
2. Data
3. Dx/Mgt
4. MDM
5. CPT code
6. H&P Documentation Requirements



*"Hats off to you! You're a doctor's
doctor, a coder's ally and an
administrator's hero."*

Lynn Wilette, RHIT, Director HIM, Deaconess

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