Hospice & Palliative Care Association of Michigan  
Palliative Care Reimbursement Seminar  
September 17, 2014  
Presented by:  
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- This presentation is a general summary that explains certain aspects of the Medicare Program and other reimbursement and compliance information, but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings.

"10 Iron Rules of Medicare"*

*Quote from Attorney Larry Oday; Modern Healthcare/June 19, 2000

1. Just because it has a code, that doesn’t mean it’s covered.
2. Just because it’s covered, that doesn’t mean you can bill for it.
3. Just because you can bill for it, that doesn’t mean you’ll get paid for it.
4. Just because you’ve been paid for it, that doesn’t mean you can keep the money.
5. Just because you’ve been paid once, that doesn’t mean you’ll get paid again.
6. Just because you got paid in one state doesn’t mean you’ll get paid in another state.
7. You’ll never know all the rules.
8. Not knowing the rules can land you in the slammer.
9. There’s always some schlemiel who doesn’t get the message.
10. There’s always some schmendrik (jerk) who gets the message and ignores it.
AGENDA

- Medical Necessity
- General E&M Documentation Guidelines
- The 3 Key Components
- Billing Based on Time
  - Counseling and Coordination of Care
  - Prolonged Services
  - Discharge Day Management

OIG RISK AREA:
Medical Record Documentation*

- Validates
  - The site of service
  - The appropriateness of the services provided
  - The accuracy of the billing
  - Identity of the care giver (provider)

*OIG’s Physician Compliance Guidance

Risk Area:
Medical Record Documentation

- Each encounter should
  - Be complete and legible
  - Every page in the chart should have the patient’s name and date of service.
  - Document the reason for the encounter
  - Have a documented impression
  - Have a documented plan of care/ follow-up
  - Be dated and have the identity of the provider
    - Sign, initial, typed name on dictation
    - All providers and staff
Medical Necessity

Medicare law requires that in order for expenses incurred for items or services to be covered, they must be "reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."

CMS Glossary for Beneficiaries defines medical necessity as: "Services or supplies that: are proper and needed for the diagnosis or treatment of your medical condition, are provided for the diagnosis, direct care, and treatment of your medical condition, meet the standards of good medical practice in the local area, and aren't mainly for the convenience of you or your doctor."

Medical Necessity

(Pub 100-4, Medicare Claims Processing Manual, Ch. 12, §30.6)

"Medical necessity is the overarching criterion for payment, in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of service than is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service billed."

This is nothing new...

"The law requires that Medicare pay only for medically necessary services, which requires judgments about the type and quantity of services that are medically necessary. For example, Medicare may determine that one physician visit per month to a nursing home resident would be medically necessary (absent other medical complications) and would pay for one such visit. However, a Medicare beneficiary who wanted more frequent visits (absent medical complications) could pay for them out of his or her own funds, even though the carrier determined the additional visits not to be reasonable and necessary."
+ Briefly: Medical Necessity & E/M

- Documentation software may facilitate carry-overs and repetitive fill-ins of stored information.
- Even when a "complete" note is generated, only medically necessary services for condition of patient at time of encounter as documented can be considered when selecting appropriate level of E/M service.
- Information not pertinent to patient's condition at time of encounter cannot be counted.
  o Patient seen in 'routine' follow-up of stable pain
  o History is "comprehensive" including past, family & social history. Was it "medically necessary" to repeat these history elements?

+ Let's talk hospice for a minute.....What Physician Services Are NOT/Are Billable?

- Are NOT:
  - Administrative Activities
  - Medical director
  - General supervisory services
  - Physician member of IDG (team physician)

- Visits to Hospice patients performed by a Nurse Practitioner (NP), if the specific NP has not been formally elected as the Hospice Attending.

+ Administrative Activities

- Activities covered by the Medicare Part A per diem rate.
  - They consist of "participating in the establishment, review and updating of plans of care, supervising care and services, and establishing governing policies."
  - "Generally performed by the physician serving as the medical director and the physician member of the interdisciplinary group."
  - It appears as if a visit performed solely to comply with Medicare's upcoming "face-to-face encounter" at 180 days and at every subsequent 60-day recertification would fall under this category.
Patient Care Services

- You can bill Medicare for these services separately:
  - Medical services that relate to the treatment and management of the patient's terminal illness and are rendered by a physician who is either employed by or has contracted with the hospice to provide the services.
  - Or those services by an ARNP who the patient has elected as the hospice attending physician or via palliative care.
  - Semantics mean something
    - Plan of Treatment
    - Billable medical service
    - Plan of Care
    - Part of the hospice benefit, paid in the per diem
  - Encounters not meeting the medically necessary test include
    - Waiting for family meeting
    - Trying to determine who the decision maker(s) is (are)

The Palliative Care Consultation

- Medicare does not pay for Consultation CPT codes
  - 65+ years of age
  - Certain disabled individuals
- Some commercial payers do honor consultation codes
  - 99281-99285
  - The "3 Rs"
    - Request (by another physician/NPP)
    - Recommendation(s)
    - Report (in writing back to that requesting physician/NPP)

Med. Necessity – Subsequent Visits

- Why should this visit be billable?
- Substantiate the reason you are seeing the patient TODAY!
  - What treatment decisions need to be discussed/made?
  - Describe the symptoms you are treating
- Patient may have Dx of Metastatic Ca
  - Is that why you are in the room?
  - Typically not seen daily to manage the Ca
- Document the medical reason for this visit.
  - NOT “Palliative care follow-up”
  - NOT “Supportive care”
Patients in SNF, ALF or Home

- Hospice or PC
- Cannot be seen and billed just because you are at the SNF, ALF or passing by the home
- Nor because the patient was “admitted to the program”
- Must be sure to paint a clear picture of the services you are providing
- Patients likely still receiving care from their PCP

Duplicative vs. Concurrent Care (Particularly for Palliative Care)

- Concurrent Care
  - “reasonable and necessary services of each physician rendering concurrent care could be covered where each is required to play an active role in the patient’s treatment, for example, because of the existence of more than one medical condition requiring diverse specialized medical services.”
  - 1) Does the patient’s condition “warrant the services of more than one physician on an attending (rather than consultative) basis?”, and
  - 2) are the services provided by each physician/NPP “reasonable and necessary?”

Duplicative vs. Concurrent Care

- Duplicative Care
  - Medicare Benefit Policy Manual: Chapter 15, Section 30 E.
  - Clearly warns Medicare contractors to “assure that the services of one physician do not duplicate those provided by another.”
HPI & Impression/Plan: The Most Important?

- **HPI**
  - Description of the illness/problem from its onset or since the last time patient seen…

- **Impression/Plan**
  - Not only indicates what today’s findings and thought processes are, but substantiates future intervention!

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Split/Shared Visits
(Part B only!!)

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IOM Publication 100-04, Chapter 12, Section 30.6.13 (H) states that, "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."
Hospital Visit Guidelines

Split/shared visits

- Inpatient E/M visit shared between physician and Non-Physician Practitioner (NPP) from same group
- Physician provides any face-to-face portion of E/M encounter - service billed under either physician’s or NPP’s National Provider Identifier (NPI)
- Hospital inpatient/outpatient/ED only
- Seen by ARNP - No face-to-face encounter between patient and physician (even if physician reviewed patient’s medical record) - service billed under NPP’s NPI only

Split/Shared E/M Service

- Hospital Inpatient/Observation Care
  - When the E/M is shared between a physician and NPP from the same group practice, and the physician provides any face-to-face portion of the E/M encounter, service may be billed under either’s NPI.
  - Physician documentation of something from at least one key component personally performed and documented:
    - History,
    - Exam, and/or
    - Medical decision making (impression/plan)

Unacceptable Documentation of Split/Shared E&M Service

- “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
- “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
## Final Notes on Split/Shared Services

- There must be documentation of the face-to-face portion of the E/M encounter between the patient and the physician.

- Medical record should also clearly identify the part(s) of the E/M service which were personally provided by the physician, and which were provided by the NPP.
  - Each signs their own individual entry.

- In the absence of such documentation, the service may only be billed under the NPP’s provider number.

- This applies to the
  - initial history and physical examination/admission note,
  - discharge summary, and
  - subsequent hospital visits.

## E&M Documentation

### 7 Components Define E&M Services:

**Key elements in selection of level**
- History
- Examination
- Medical decision making

**Ancillary elements in selection of level**
- Counseling
- Coordination of care
- Nature of presenting problem (medical necessity)
- Time
Using time to assign the level of E&M service.

- If a visit consists primarily of counseling or coordination of care, time is the key element to assign the appropriate level of E&M service.
- The total length of time of the encounter should be documented and the record should describe the counseling and/or activities to coordinate care.

To be discussed a bit later....

Let’s look at the 3 Key Components

#1: Documentation of History

- Based on 4 types
  - Problem Focused
  - Expanded Problem Focused
  - Detailed
  - Comprehensive

- History elements
  - Chief Complaint (CC)
  - History of present illness (HPI)
  - Review of systems (ROS)
  - Past, family and/or social history (PFSH)
**Chief Complaint**

- Concise statement describing symptoms, problems, condition, physician recommended return, or other factor that is the reason for the encounter.

- Chief complaint must be explicitly stated or easily inferred from documentation:
  - “Severe abdominal pain for past 8 hours” (explicit)
  - “Less agitation since adding Ativan” (inference is that visit is to F/up on medication change)
Review of Systems

- Constitutional symptoms; e.g. fever
- Eyes
- Ears, Nose, Mouth, Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary
- Neurological
- Psychiatric
- Endocrine
- Hematologic/Lymphatic
- Allergic/Immunologic

Review of Systems (ROS)

- Inventory of body systems obtained by questions to identify signs/symptoms patient is or has been experiencing
- For all levels of ROS, positive responses and pertinent negative responses must be documented.
- 3 Levels of ROS
  - Problem pertinent addresses system directly related to problem identified in HPI
  - Extended addresses system related to problem & a limited number of add’l systems (total of 2-9 systems)
  - Comprehensive – see next slide

Review of Systems (ROS), cont.

- Complete ROS addresses system related to problem plus all add’l body systems.
  - At least 10 organ systems, must be reviewed
  - For remaining systems, notation indicating “all other systems negative” may be permissible
  - In the absence of this notation, at least 10 systems must be individually documented
Past, Family and/or Social History consists of:

- 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); and
- Social history (an age appropriate review of past and current activities).

When History is Unobtainable

- Times when you cannot obtain a history from patient, due to patient’s condition, and there may be no one else present with knowledge of patient’s history.
- This situation does not automatically qualify as a comprehensive history.
- Must document your attempts to obtain the missing history element(s) from other sources (eg., chart, nurses, family).

Palmetto's Perspective

Question: If the physician determines that the patient needs a difficult history without further discussion, is this documentation sufficient?
Answer: Yes, the physician should document why the patient needs a difficult history, and whether the patient’s condition prohibits further discussion.

Question: If a member of the medical team is unable to obtain a history from the patient or a family member, can they document the difficulty in obtaining the history?
Answer: Yes, if a member of the medical team is unable to obtain a history from the patient or a family member, they should document the difficulty and the steps taken to obtain it.
History Documentation Guidelines

- History documentation is dependent upon the physician:
  - Clinical judgment
  - Nature of presenting problem(s)
- CC, ROS, and PFSH - list separate or w/the HPI
- ROS and/or PFSH obtained prev. does NOT have to be re-recorded. Documentation should reflect that the physician reviewed the previous entry noting the date and location.
- ROS and/or PFSH can be recorded by the patient or ancillary staff.
- If you are unable to obtain a patient history, document why and your attempt to obtain from another source.

Selecting *Level of History

<table>
<thead>
<tr>
<th>HPI</th>
<th>ROS</th>
<th>PFSH</th>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief (1-3</td>
<td>N/A</td>
<td>N/A</td>
<td>Problem Focused</td>
</tr>
<tr>
<td>elements)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brief (1-3</td>
<td>Problem Pertinent (system directly related to problem identified in HPI)</td>
<td>N/A</td>
<td>Expanded Problem Focused</td>
</tr>
<tr>
<td>elements)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extended (4 or more elements)</td>
<td>Extended (system directly related to problem identified in HPI &amp; a limited # of add'l systems - 2-9 total)</td>
<td>Pertinent (at least 1 specific item from any of the 3 areas)</td>
<td>Detailed</td>
</tr>
<tr>
<td>Extended (4 or more elements)</td>
<td>Complete (system directly related to problem identified in HPI &amp; all add'l systems or a minimum of 10 systems)</td>
<td>Complete (2 or all 3 of the PFSH depending on E/M category)</td>
<td>Comprehensive</td>
</tr>
</tbody>
</table>

*To qualify for a given level of history, all 3 elements in the history table must be met.

Tips from PalmettoGBA....

3. Record full uncomplicated History (HPI) - essentially consisting of the classical description of the complaint. Never code E/M in association with HPI.
   - Do not use modifiers "not elsewhere classified." (NOS) unless the patient required in-office evaluation and management (E/M) services, e.g., physical therapy, occupational therapy, psychological counseling and home, as well as non-consultative and non-consultative Neurology (NF) examinations.
   - Do not report an exacerbation or relapse severity to meet vague medical necessity guidelines. However, when there is a clear exacerbation, a lower level service to have been rendered is appropriate.
Tips from PalmettoGBA….

4. Select the Review of Systems (ROS) appropriate for the clinical circumstance of the encounter. If questionable, ROS is recommended for known and new problems.
   • Document ROSE for the systems related to the presenting problem. ROS is required for all systems. (Checkboxes below indicate systems included in the recommendations.)
   • The grouped systems can be checked either as a group or by individual system(s). Code only the systems included in the problem list.

#2: Documentation of Exam (1995 DG)

**Comprehensive:** Gen’l multi-system (8+ OS) or complete single system organ system exam.

<table>
<thead>
<tr>
<th>Body Areas</th>
<th>Organ Systems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head, including face</td>
<td>Constitutional</td>
</tr>
<tr>
<td>Neck</td>
<td>Eyes</td>
</tr>
<tr>
<td>Chest, incl. breasts &amp; axillae</td>
<td>Ears, Nose, Mouth, Throat</td>
</tr>
<tr>
<td>Abdomen</td>
<td>Cardiovascular</td>
</tr>
<tr>
<td>Genitalia, groin, buttocks</td>
<td>Respiratory</td>
</tr>
<tr>
<td>Back, incl. spine</td>
<td>Gastrointestinal</td>
</tr>
<tr>
<td>Each extremity</td>
<td>Genitourinary</td>
</tr>
<tr>
<td></td>
<td>Musculoskeletal</td>
</tr>
<tr>
<td></td>
<td>Skin</td>
</tr>
<tr>
<td></td>
<td>Neurologic</td>
</tr>
<tr>
<td></td>
<td>Psychiatric</td>
</tr>
<tr>
<td></td>
<td>Hematologic/lymphatic/immunologic</td>
</tr>
</tbody>
</table>

**Documentation of Exam**

<table>
<thead>
<tr>
<th>Problem Focused</th>
<th>A limited exam of the affected body area or organ system (1+ BA/OS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expanded problem focused</td>
<td>A limited exam of the affected body area or organ system and any other symptomatic/related area(s)/system(s) (2-7 BA/OS)</td>
</tr>
<tr>
<td>Detailed</td>
<td>An extended exam of the affected body area(s) or organ system(s) and any other symptomatic or related area(s)/system(s) (2-7 BA/OS)</td>
</tr>
<tr>
<td>Comprehensive</td>
<td>Gen’l multi-system (8+ OS) or complete single organ system exam.</td>
</tr>
</tbody>
</table>
**EPF v. Detailed Exam - Example**

- **Expanded Problem Focused exam** “a limited examination of the affected body area or organ system and other symptomatic or related organ system(s)” 2-7 BA/OS
- **Detailed exam** “an extended examination of the affected body area(s) and other symptomatic or related organ system(s)” 2-7 BA/OS

Constitutional: VSS
Heart: EER
Lungs: Clear

Constitutional: VSS. Well developed, well nourished white female in no acute distress.
Heart: EER. S1 S2. No murmurs, rubs or gallops.
Lungs: Clear to P&A. Normal expiratory effort w/decreased breath sounds noted. No rales or rhonchi.

**Exam guidelines**

- Specific abnormal and relevant negative findings should be documented. A notation of “abnormal” w/o elaboration is insufficient.
- Abnormal or unexpected findings of any asymptomatic area(s)/system(s) should be described.
- A brief statement indicating “negative” or “normal” is sufficient to document normal findings related to unaffected area(s) or asymptomatic system(s).

**#3: Medical Decision making**

(2:3 variables required)

1. The number of possible diagnoses/number of management options that must be considered
2. Amount/complexity of medical records, diagnostic tests, &/or other information obtained, reviewed and analyzed
3. Risk of significant complications, morbidity &/or mortality, as well as comorbidities associated w/the patient’s presenting problem(s), the diagnostic procedure(s), &/or possible management options

- Each variable can be one of four levels: from minimal/none to extensive/high.
# DX/Mgmt Options

<table>
<thead>
<tr>
<th>Number of Diagnosis/Management Options</th>
<th># X Points</th>
<th>= total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self limited or minor (recovered, or recovering)</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Intensive care required (ICU)</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Established problem requiring MD.</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>New problems encountered MD. no. additional work up planned - minimum of 1 point in this category</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>New problems (to examining MD.)</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>4+ new problems addressed</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Legend for #s and # of Data:
- Minimal/Level I = 1 pt
- Moderate/Level III = 3 pts
- High/Level V = 4 pts

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# Amount/Complexity of Data

<table>
<thead>
<tr>
<th>Amount/Complexity of Data Required</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moreover when clinical or lab tests are ordered</td>
<td>1</td>
</tr>
<tr>
<td>Moreover when order tests in this ordering location of CPIT-1 &amp; brain imaging are not ordered</td>
<td>1</td>
</tr>
<tr>
<td>Moreover when order tests in this ordering location of CPIT-1 &amp; heart imaging are not ordered</td>
<td>1</td>
</tr>
<tr>
<td>Moreover when order tests in this ordering location of CPIT-1 &amp; abdominal imaging are not ordered</td>
<td>1</td>
</tr>
<tr>
<td>Moreover when order tests in this ordering location of CPIT-1 &amp; diagnostic procedures are not ordered</td>
<td>1</td>
</tr>
<tr>
<td>Moreover when order tests in this ordering location of CPIT-1 &amp; diagnostic procedures on patient are not ordered</td>
<td>1</td>
</tr>
<tr>
<td>Moreover when order tests in this ordering location of CPIT-1 &amp; diagnostic procedures on patient are not ordered</td>
<td>1</td>
</tr>
<tr>
<td>Moreover when order tests in this ordering location of CPIT-1 &amp; diagnostic procedures on patient are not ordered</td>
<td>1</td>
</tr>
<tr>
<td>Moreover when order tests in this ordering location of CPIT-1 &amp; diagnostic procedures on patient are not ordered</td>
<td>1</td>
</tr>
<tr>
<td>Moreover when order tests in this ordering location of CPIT-1 &amp; diagnostic procedures on patient are not ordered</td>
<td>1</td>
</tr>
</tbody>
</table>

Legend for #s and # of Data:
- Minimal/Level I = 1 pt
- Moderate/Level III = 3 pts
- High/Level V = 4 pts

---

# Table of Risk

<table>
<thead>
<tr>
<th>Level</th>
<th>Presenting Problems</th>
<th>Management Options</th>
<th>Management Support Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level I</td>
<td>Acute problems with minor complications</td>
<td>Protect against dehydration</td>
<td>Associated Educational Hours</td>
</tr>
<tr>
<td>Level II</td>
<td>Clinical problems with complications</td>
<td>Protect against dehydration</td>
<td>Associated Educational Hours</td>
</tr>
<tr>
<td>Level III</td>
<td>Clinical problems with complications</td>
<td>Protect against dehydration</td>
<td>Associated Educational Hours</td>
</tr>
<tr>
<td>Level IV</td>
<td>Clinical problems with complications</td>
<td>Protect against dehydration</td>
<td>Associated Educational Hours</td>
</tr>
<tr>
<td>Level V</td>
<td>Clinical problems with complications</td>
<td>Protect against dehydration</td>
<td>Associated Educational Hours</td>
</tr>
</tbody>
</table>

Legend:
- Level I: Minimal/Level I
- Level II: Moderate/Level III
- Level III: High/Level V

17
Determining MDM

Putting these elements together…

<table>
<thead>
<tr>
<th>Medical Decision Making</th>
<th>Straight-forward</th>
<th>Low</th>
<th>Moderate</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem of Diagnosis or Management</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4 or more</td>
</tr>
<tr>
<td>Number and Complexity of Tests</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4 or more</td>
</tr>
<tr>
<td>General area</td>
<td>straigt</td>
<td>low</td>
<td>moderate</td>
<td>high</td>
</tr>
</tbody>
</table>

Which equates to…

Consultation: 99244/99254
Documentation Required (all of the below)

1. Comprehensive History
   - Chief complaint
   - HPI (4 or more elements; e.g. location, severity, quality, timing, context, modifying factors, etc.)
   - ROS – 10 or more systems
   - Past/Family/Social History

2. Comprehensive Exam (8 or more body areas/organ systems)

3. Medical Decision Making of Moderate Complexity (at least 2 of the following)
   - Moderate # of diagnoses or management options
   - Moderate amount or complexity of data (to be) reviewed
   - Moderate degree of risk

Consultation: 99245/99255
Documentation Required (all of the below)

1. Comprehensive History
   - Chief complaint
   - HPI (4 or more elements; e.g. location, severity, quality, timing, context, modifying factors, etc.)
   - ROS – 10 or more systems
   - Past/Family/Social History

2. Comprehensive Exam (8 or more organ systems)

3. Medical Decision Making of Moderate Complexity (at least 2 of the following)
   - Extensive # of diagnoses or management options
   - Extensive amount or complexity of data (to be) reviewed
   - High degree of risk
### Initial Hospital Care

<table>
<thead>
<tr>
<th>Code</th>
<th>History</th>
<th>Physical</th>
<th>Diagnosis</th>
<th>Classification</th>
<th>Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>0000</td>
<td>DKA, NS, pH 7.3</td>
<td>NS NS 7.3</td>
<td>[details]</td>
<td>[details]</td>
<td>[details]</td>
</tr>
<tr>
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### Subsequent Hospital Visits

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<th>Code</th>
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<th>Physical</th>
<th>Diagnosis</th>
<th>Classification</th>
<th>Documentation</th>
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**Questions?**