

Yes you can teach E/M to your physicians

Compiled and Presented by:

Suzan Berman, CPC, CEMC, CEDC



Objectives

- Getting to know your material
- Getting to know your audience
- Getting the right tools for effective education
- Gathering the pertinent information
- Knowing how much time you really need
- Knowing the atmosphere and setting

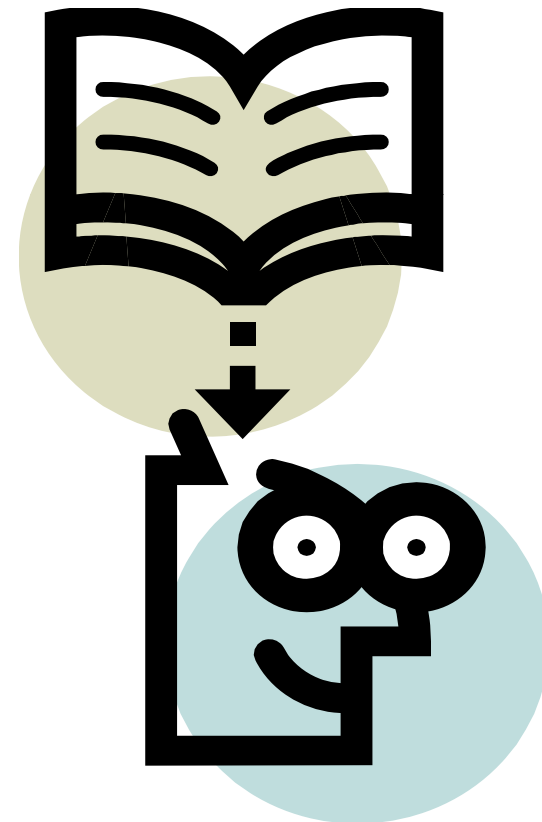


Question about your material

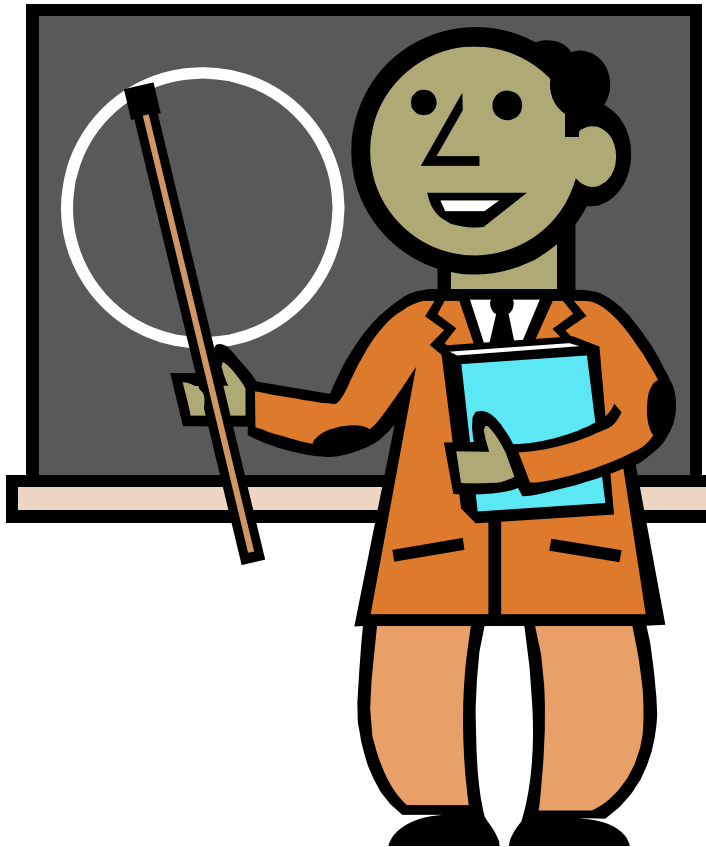
- ❑ Is it new information to your audience?
- ❑ Is it technical and complicated?
- ❑ Is it information they know and there are new policies, procedures, aspects that need to be conveyed?
- ❑ Is the session a required repetition of known information?

You and your material

- You need to be the expert of your information.
 - Don't be afraid to NOT know something though.
- You need to know how the information will flow in your presentation.
- Make certain to back your information up with resources and/or examples when available.



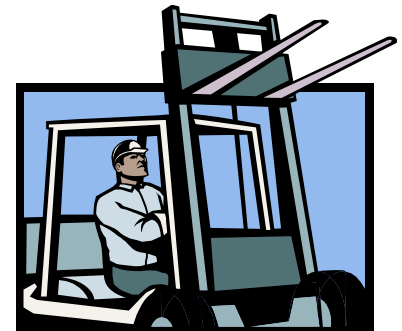
Knowing your material



- Adapt your material to the level of expertise of the majority of your audience members.
- Know when to interject examples, humor, illustrations, and review questions.
- Don't bog your audience down with unnecessary details.

Questions about your audience

- How many people will you be instructing?
- Have you met with these people before?
- Your material and the way in which you present could be very different depending on the type of people you are instructing.
 - Faculty
 - Colleagues
 - Staff and Sub-ordinates





Familiarity of the audience

- Will your close colleagues be there or will these be people you have never met before?
- Have you presented to people of similar background/position in the past?
- Does your audience know about your position/task, the information you will be providing?

Audience size



- Size is extremely important....when it comes to instruction.
- Knowing this in advance will provide you with a lot of needed confidence, information, and stature.
- If you are talking with just one person, try to find out his/her level of knowledge of your material.



Perfect time for an example

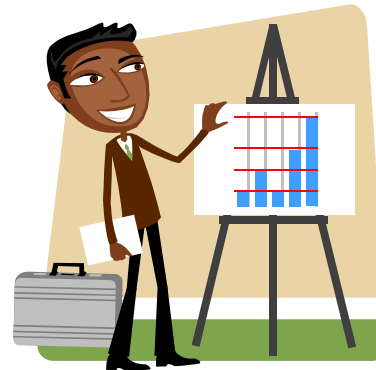
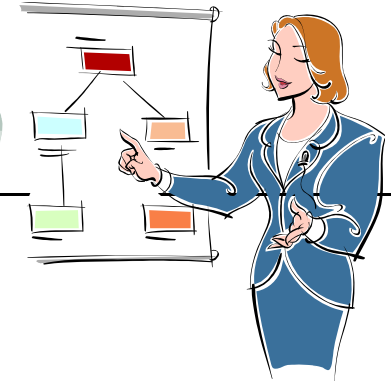
- Your physicians know there are documentation guidelines that have been in place since 1995/1997.
 - But, how do you present the information to them illustrating how it applies to their day-to-day operations?
 - Have you met with them previously and this is a refresher course?
 - Do they know anything about billing and the guidelines?

Presentation style

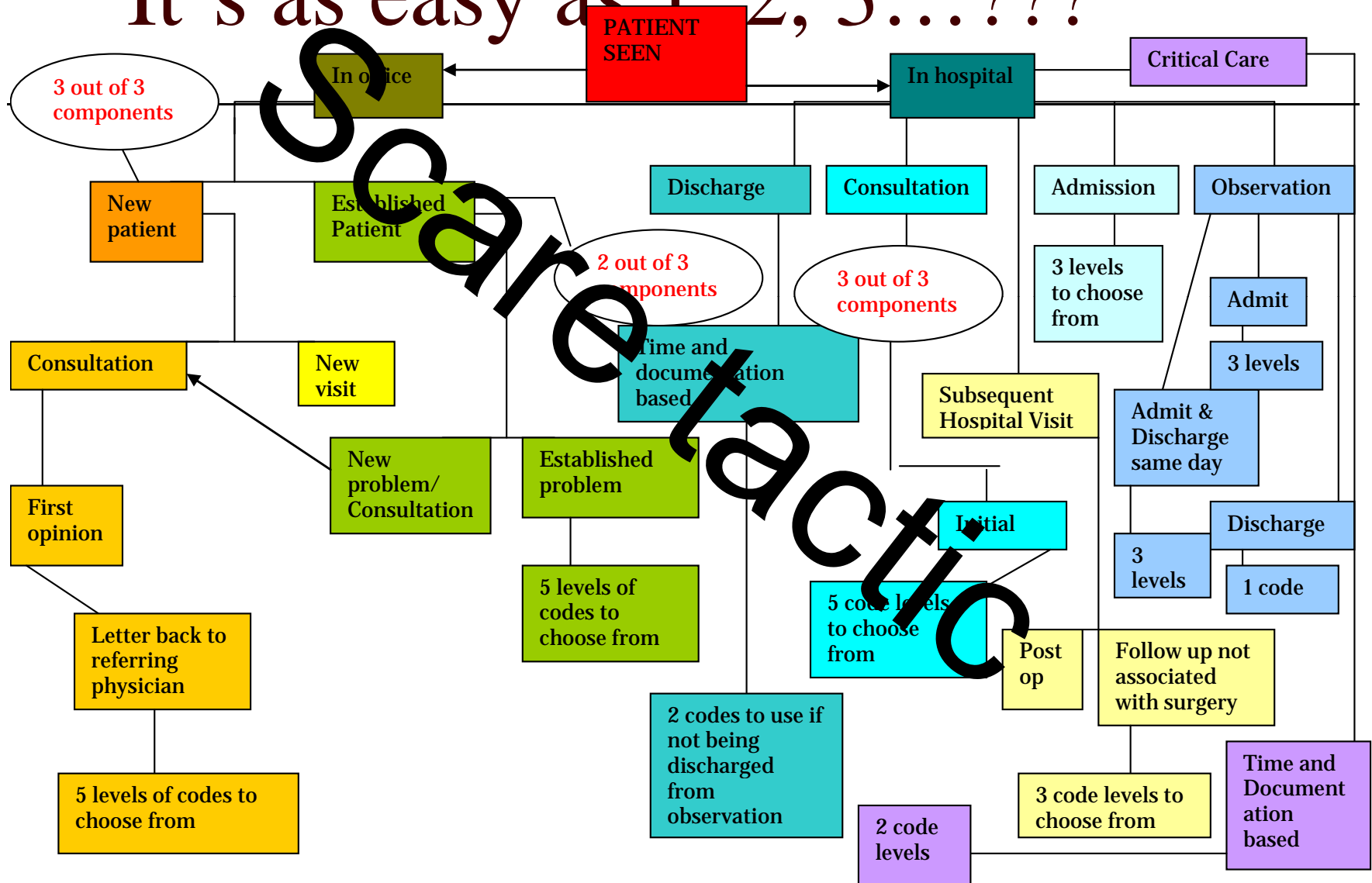


- As you know, the E/M guidelines aren't the easiest.
 - Have the physicians ever billed?
 - Have they been instructed on the guidelines before?
 - Are they required to be in the session or are they choosing this seminar?
 - Bring the presentation to them.
 - Logically
 - Realistic
 - Level of Understanding

Try this one



It's as easy as 1, 2, 3...???





What is an E/M code?

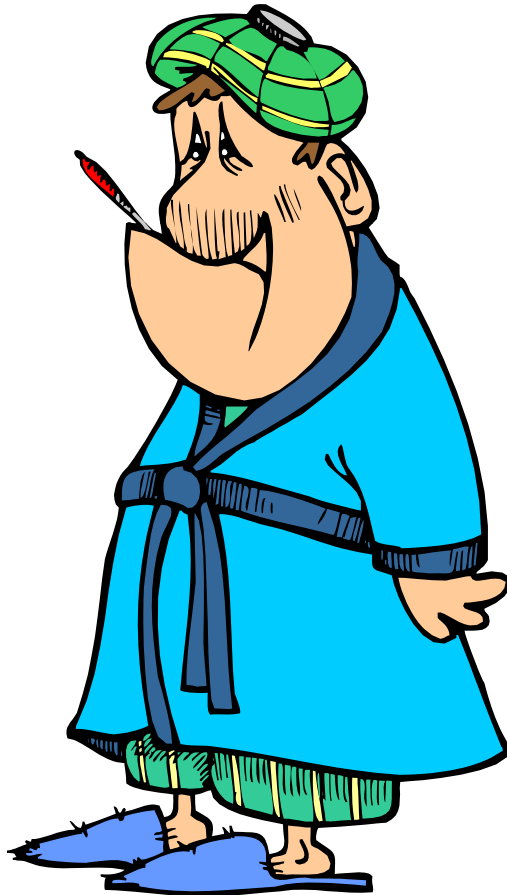
- E/M stands for evaluation and management
 - These are used for encounters between patients and healthcare professionals.
 - They can be in-patient, out-patient, consultations, critical care visits, etc.
 - *(They need to understand the language that will be used in the presentation as well as in their daily activity.)*

How to pick the right code

Following the 5 D's!

- **D**etermine where you are.
 - *Office, Hospital, Pt. Home, Nursing Home, etc.*
- **D**etermine what type of patient you are seeing.
 - *Established vs. New*
- **D**etermine what type of visit you are performing.
 - *Visit, Observation, Consultation, Critical Care, etc.*
- **D**ocument completely and accurately to establish reasonable and medically necessary.
- **D**etermine the level of care you have rendered.
 - *Straightforward, Problem Focused, Expanded Problem Focused, Comprehensive, or Detailed.*

Clearly state Chief Complaint



- This can be written in the patient's words.
- This is the reason for the encounter.
- A specific reason- not just a follow up is suggested.
- *Explain the requirement then follow with a practical example*



History of Present Illness

- Location
- Quality
- Severity
- Duration
- Timing
- Context
- Modifying Factors
- Associated Signs and Symptoms
- 1-3 Brief
- 4+ extended

Provide all the guidelines and then offer suggestion on incorporation (Forms, words, phrases, EMR, etc.)



Sample HPI

- I want to thank you for asking me to consult on your patient Mrs. Mary Rodgers. She is a 68-year-old lady who is being followed by you for a left upper lobe mass (*location*) (*Chief complaint is now established.*) as well as a 2 cm (*severity*) lymph node in her AP window. During her evaluation, (*context*) there was some question regarding a history of aortic stenosis. You therefore suggested she see me for possible options.
- The above HPI can only help to satisfy code levels up to a 99202 or a 99242.



A better example

- I saw Mr. Hopper in my surgical clinic at University Hospital. ...He relates that he began to have some dyspnea (*sign/symptom*) on exertion (*context*) approximately a year ago (*duration*). He originally presented to General Hospital He was seen there and ultimately found to have a sizable (*severity*) arachnoid cyst located in the cerebella region (*location*).... Nevertheless, he underwent a cardiac workup. A stress test was found to be positive (*context*) and he ultimately went for cardiac catheterization and for echocardiography. This demonstrated rather severe (*severity*), presumably ischemic, cardiomyopathy with an estimated ejection fraction.... The patient's symptomatology is relatively benign. He related that he did have some peripheral edema and some exertional dyspnea (*signs/symptoms*).
- As documented, this HPI (with more than 4 elements) clearly helps to substantiate the highest levels of service.

Past History



Intersperse the guidelines with examples. This will bring the focus back to the lesson.

- Allergies
- Current Medications
- Immunizations
- Previous Trauma
- Surgeries
- Previous Illness
- Previous Hospitalizations

Family History



- Health of Parents or cause and age of death
- Health of Siblings and Children
- Family Members with disease related to the Chief Complaint

Social History

- ❑ Drug use
- ❑ Alcohol consumption
- ❑ Tobacco use
- ❑ Employment
- ❑ Sexual history
- ❑ Marital status
- ❑ Education
- ❑ Occupational history



Pictures, humor, and slide formatting are also important to interject.

Documenting ALL histories

- Past Medical History: Significant for coronary artery disease with ischemic cardiomyopathy as mentioned above. He also has a history of hypertension (*Past history-prior illness*). He also has a history of hyperlipidemia. He is not diabetic. He does not complain of SOB (*ROS-Respiratory*) and denies any chronic medical problems.
Past Surgical History: Includes surgery to his right shoulder x 3. (*Past history-surgical history*)
Allergies: HE HAS NO KNOWN ALLERGIES. (*ROS-Allergy/Immunology*)
- Current Medications:Paxil, vitamin B6... (*Past History-Current Meds*)
- *No further histories are mentioned. This could help toward billing up to a 99203 or a 99243.*

Time for a few other examples.



Another example

- The patient's past medical history is notable for hyperlipidemia (*Past history-illness*) and a bicuspid aortic valve. He does have known coronary artery disease and previously underwent a PTCA of the circumflex artery in 1996. He has no prior surgical history (*Past history-surgery*), and HAS NO KNOWN DRUG ALLERGIES (*Past history-allergies or ROS-allergy/immunology*). His medications include Lopressor (*Past history-meds*).... The patient is a former 20-pack-year smoker (*Social history-tobacco use*) and does not drink regularly (*Social history-alcohol use*). Family history is negative for any heart disease (*Family history*).
- All three (3) histories (Past, Family, and Social) are illustrated in order to substantiate medically necessary higher levels of service.

What if these histories are unobtainable?

- In order to get the proper credit for the history retrieval, you must document the following:
 - Any attempts you made to get the history
 - “I spoke with the resident/nurse/family to gather the patients medications.”
 - Why weren’t these details obtainable?
 - “The patient’s condition was of an urgent nature. Gathering the social history was not warranted at this time.”
 - “Gathering the patient’s family history was not pertinent to the patient’s emergent condition.”

Answer a question before it’s asked. This let’s your audience know you understand their role and their work process.



Review of Systems

- Constitutional
- Eyes
- Ears, Nose, Mouth/Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Allergic/Immunologic
- Integumentary
- Neurological
- Endocrine
- Psychiatric
- Hematologic/
Lymphatic
- Musculoskeletal
- All others reviewed
and negative



Review of Systems example

- Review of systems: She complains of severe lower extremity swelling and dyspnea (cardiac) on exertion. She also has PND (respiratory). She also has a question of a TIA (neuro) and has carried the diagnosis of lupus cerebritis. Approximately 1 month ago, she complained of left leg and arm numbness. The patient reports to me ...that she has not had a heart murmur.
- With other any other systems mentioned, this ROS can only help to substantiate levels of service up to a 99203 or 99243.
- In order to help this ROS, had more questions been asked and were negative or had the patient completed a multi-system questionnaire, the below statement could have been added.
 - “All other systems have been reviewed and are negative.”
 - If the information sheet completed by the patient had at least 10 systems mentioned, the above statement could be used to complete a comprehensive ROS. That sheet should also be signed and dated by the billing provider.



Will I still be able to justify my level of service if I cannot obtain a complete ROS?

- You must mention all pertinent positives and negatives of the ROS.
- If time was of the essence and a complete ROS was not obtained, you should detail the reasons.
- You should make all reasonable attempts to gather this information.
- If someone else was able to gather this information, refer to their note in yours.
 - This can be done for PFSH and ROS.



The components of the history

- History of Present Illness
 - Up to 3-brief
 - 4+ extended
- Past, Family, and Social History
 - 1 or 2 pertinent (new/consults)
 - 3 complete (2 if established)
- Review of Systems
 - 1 problem pertinent
 - 2-9 extended
 - 10+ complete

You've provided a lot of information. A summary is a good way to keep your audience focused.

Physical Examination-Element #3

□ **Body Areas**

- Head, include face
- Neck
- Chest, including breasts and axillae
- Abdomen
- Genitalia, groin, buttocks
- Back, including spine
- Each extremity

□ **Organ Systems**

- Constitutional
- Eyes
- Ears, nose, mouth/ throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary
- Neurologic
- Psychiatric
- Hematologic / lymphatic/ immunologic

You know about the different guidelines. Will your doctors **NEED** to know about both? Have they already been exposed to both?

Determine if it's necessary to give them that information.

Levels of the Physical Exam Components

□ **Problem Focused**

- 1 Body Area/Organ System

□ **Expanded Problem Focused**

- 2-7 Body Areas and/or Organ Systems

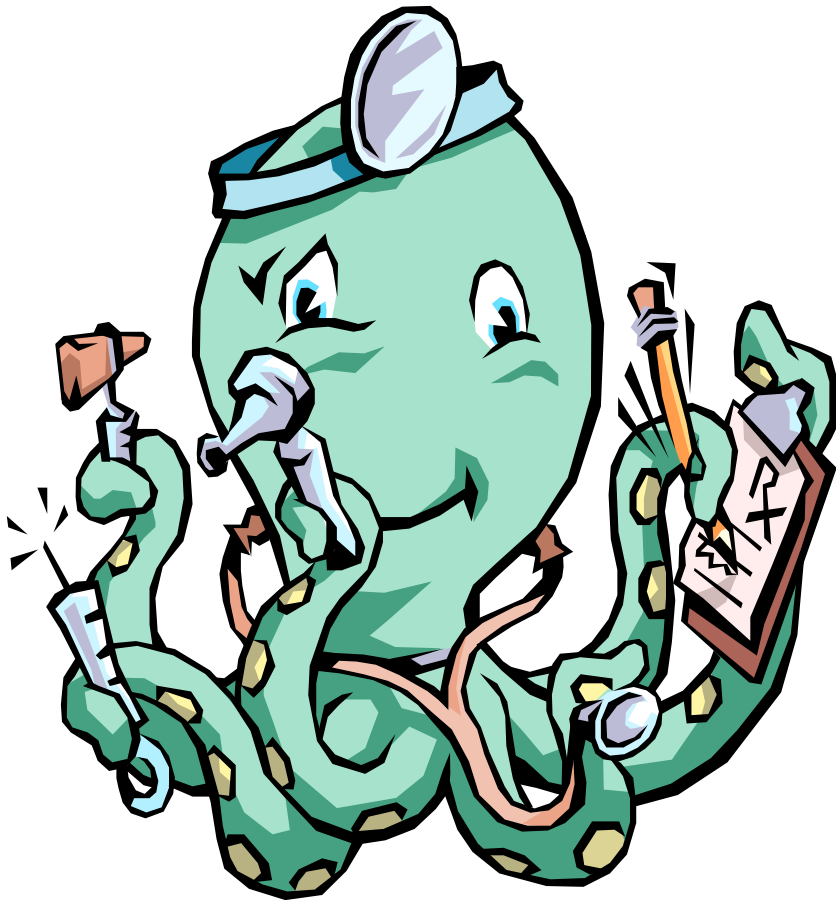
□ **Detailed**

- 2-7 Body Areas and/or Organ Systems with at least 1 being of a detailed nature

□ **Comprehensive**

- 8 or more **Organ Systems**

The patient's condition may not warrant an 8 organ system exam!



- The 8 organ system exam is required to bill any level 4 or 5 visit on a new patient or a consultation.
- A complete exam of 1 organ system can also be used to satisfy this requirement.
 - The complete exam is defined by the individual physician.
 - The standard followed by the particular specialty society or college can be used as a guide.
 - The notation should indicate clearly that a complete or comprehensive exam of the X system was done.
 - The details of that exam should also be illustrated.



Examination Example #1

- Physical examination reveals a blood pressure of 112/86, respiration 20, pulse 74 and regular. She weighs 123 pounds (*Constitutional*). Head and neck exam reveals normal jugular venous destention (*Cardiac*). Midline trachea (*Ears, Nose, and Throat*). No lymphadenopathy (*Lymphatics*). No carotid bruits (*Cardiac*). Heart sounds are normal (*Cardiac*). Peripheral pulses intact (*Cardiac*). Chest is clear to auscultation bilaterally (*Respiratory*). Abdomen is soft, nontender (*Gastrointestinal*). There is no hepatosplenomegaly of other masses (*Gastrointestinal*). She has no edema (*Cardiac*). Peripheral pulses are intact, and there are no bruits or murmurs (*Cardiac*). There is no gross motor weakness in the upper or lower limbs (*Neurological*). She has no skin lesions (*Integumentary*) and no lymphadenopathy (*Lymphatics*).
- This documentation illustrates that eight (8) organ systems have been examined. This examination could help to substantiate any level of service, include 99244, 99245 or 99204, 99205.

Medical Decision-Making

□ Management options

- Self limited/minor
- Established problem
- Worsening problem
- New problem
- Work up for new problem



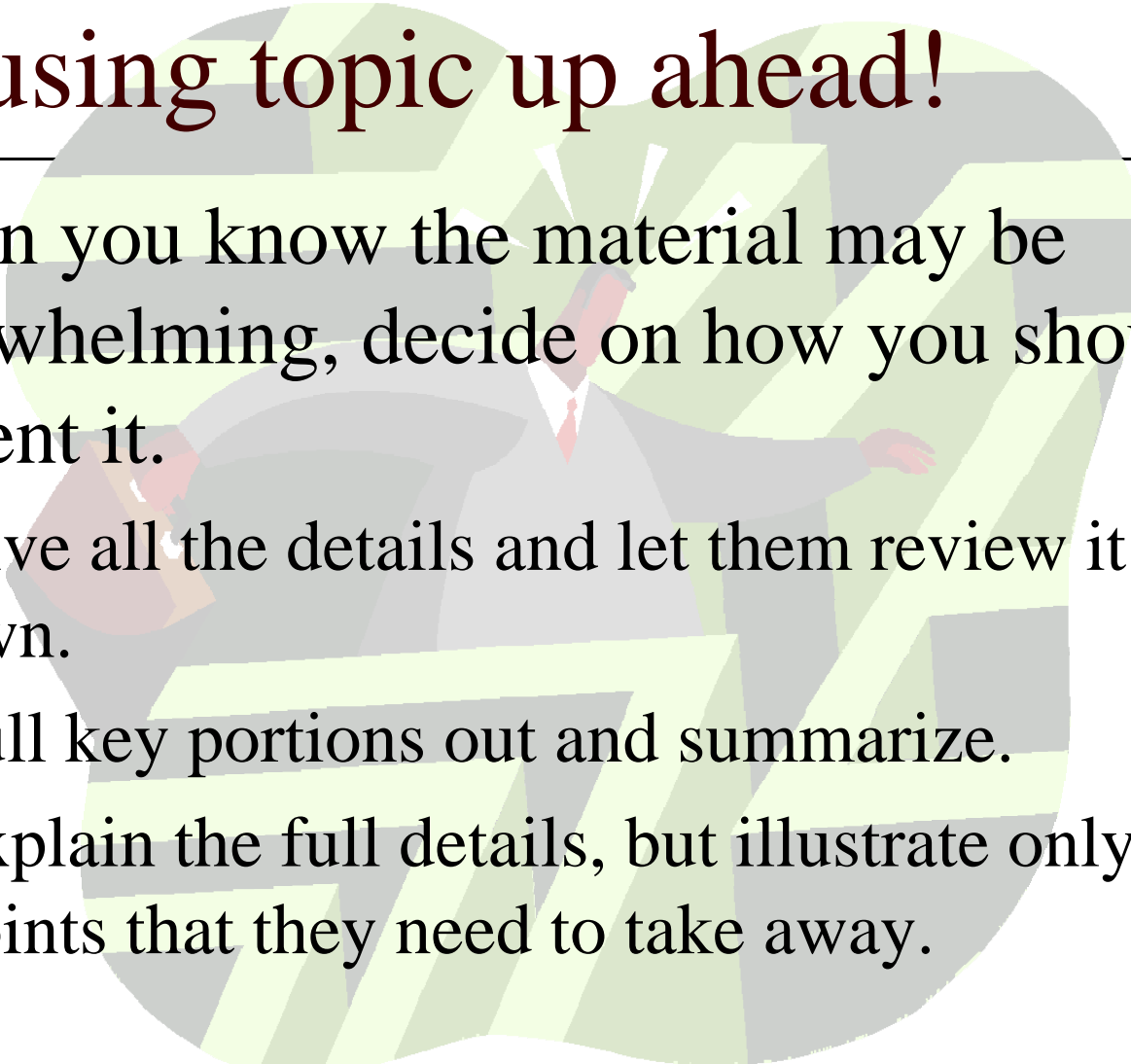
□ Amount and complexity of data

- review/order of clinical labs
- review/order tests in radiology section
- review/order tests in medicine section
- discussion of test results with performing physician
- **independent review of image, tracing or specimen**
- decision to obtain old records
- **obtain history from someone other than patient**
- review AND summarize old records



Confusing topic up ahead!



- When you know the material may be overwhelming, decide on how you should present it.
 - Give all the details and let them review it on their own.
 - Pull key portions out and summarize.
 - Explain the full details, but illustrate only the key points that they need to take away.
- 

Level of risk



- Minimal
 - Self limited/minor problem
- Low
 - 2+minor or 1 stable chronic
 - IV therapy w/o additives
- Moderate
 - Chronic illness w/ mild exacerbation
 - 2+ chronic illnesses
 - Undiagnosed new problem
 - Rx drug management
 - Elective major surgery
- High/Extensive
 - An illness w/ severe exacerbation
 - parenteral controlled drug therapy
 - elective major surgery w/ patient specific risks.



MDM Components

- ❑ Diagnoses/Management options
 - ❑ Amount and/or Complexity of the Data
 - ❑ Level of Risk
-
- ❑ Must meet two (2) out of the three (3) to reach the desired level.

What is a consult?

- A consult involves meeting the following criteria:
- Follow the 4 Rs:
 - **Request**-Another physician has asked your opinion on a specific issue the patient is having/experiencing-**Reason**.
 - There is documentation in the patient's medical record of the request and the reason.
 - **Render**-The service is rendered by you.
 - **Report**-You, then, document your findings and/or recommendations in a written report back to the requesting physician.
- Consultation can be done on both new and established patients.
- Consultations can happen in a variety of locations
 - In-patient
 - 99251-99255
 - Out-patient
 - 99241-99245
 - ER
 - 99251-99255 if admitted
 - 99241-99245 if sent home or to observation
 - Observation
 - 99241-99245

Is the documentation for a consultation more involved than for a new patient?

- There is one additional requirement that most physicians are already doing.
 - A note must be written into the patient's medical record.
 - There must be a notation indicating who asked for the consultation.
 - There must be illustration as to why the consult was requested.
 - A letter must be written back to the **requesting** physician.
 - This should include a thank you for the consultation
 - Include a brief synopsis of the visit.

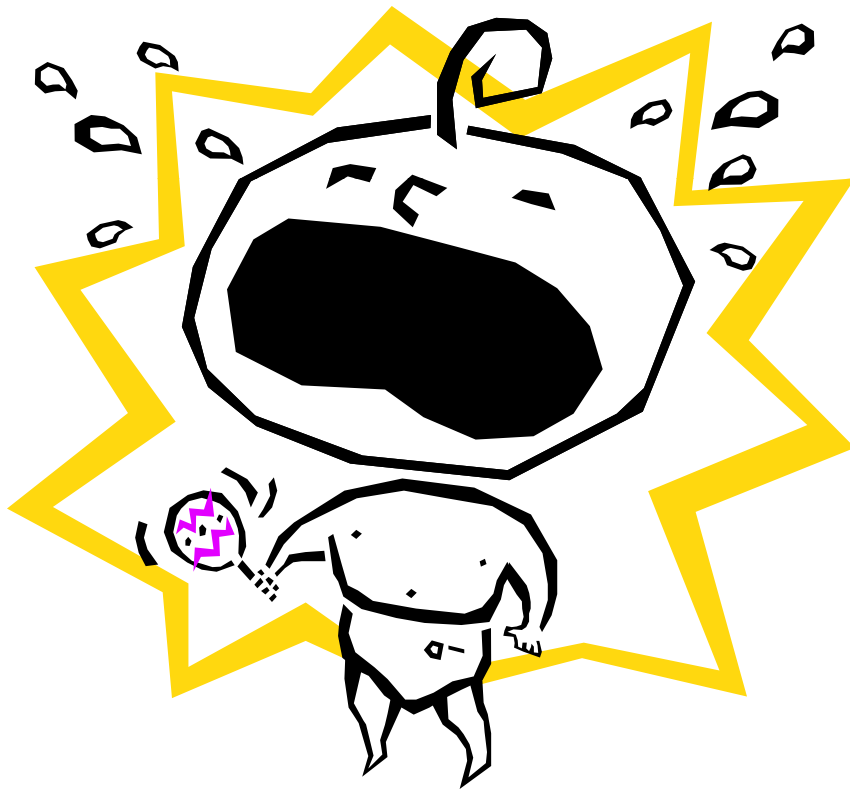




Can my clinical note be written in the form of a letter?

- Absolutely.
 - Your letter can stand as your note of the visit as well as the correspondence to the requesting physician.
 - All the required elements would then need to be written into the letter.
 - You should not, however, “CC” the requesting physician at the bottom of your clinic note.

When is a patient considered new?



- If you have never seen the patient either in your office or the hospital.
- When the patient has never been seen by anyone within your group in the same specialty within the last 3 years.

How it all adds up!

Must meet or exceed 3 out of 3 for new patients and all consults

| E&M Code | History | Exam | Decision Making |
|--|---|--|---|
| <input type="checkbox"/> Level 1- | <input type="checkbox"/> Problem Focused | <input type="checkbox"/> Problem Focused | <input type="checkbox"/> Straightforward |
| <input type="checkbox"/> Level 2- | <input type="checkbox"/> Expanded PF | <input type="checkbox"/> Expanded Problem Focused | <input type="checkbox"/> Straightforward |
| <input type="checkbox"/> Level 3- | <input type="checkbox"/> Detailed | <input type="checkbox"/> Detailed | <input type="checkbox"/> Low |
| <input type="checkbox"/> Level 4- | <input type="checkbox"/> Comprehensive | <input type="checkbox"/> Comprehensive | <input type="checkbox"/> Moderate |
| <input type="checkbox"/> Level 5- | <input type="checkbox"/> Comprehensive | <input type="checkbox"/> Comprehensive | <input type="checkbox"/> High |

Must meet or exceed 2 out of 3 for established pts./ subsequent visits

Level 1- Present problem minimal. May not require the presence of a physician. Typically 5 minutes.

| | | | |
|--|---|--|---|
| <input type="checkbox"/> Level 2- | <input type="checkbox"/> Problem Focused | <input type="checkbox"/> Problem Focused | <input type="checkbox"/> Straightforward |
| <input type="checkbox"/> Level 3- | <input type="checkbox"/> Expanded PF | <input type="checkbox"/> Expanded Problem Focused | <input type="checkbox"/> Low |
| <input type="checkbox"/> Level 4- | <input type="checkbox"/> Detailed | <input type="checkbox"/> Detailed | <input type="checkbox"/> Moderate |
| <input type="checkbox"/> Level 5- | <input type="checkbox"/> Comprehensive | <input type="checkbox"/> Comprehensive | <input type="checkbox"/> High |

Offer a tool for their day-to-day activity.

Getting back to your presentation





Questions about your presentation

- Is the information made available via a PowerPoint-type presentation?
- Are you able to provide handouts?
- What about take aways?
- Is this intimate training around a small table or desk?
- Are you able to illustrate effectively?
- Are you going to allow questions during or after the presentation?
- Are there examples you will be providing?



Questions about your available time

- ❑ Is your audience squeezing you in?
- ❑ Do you have the right amount of time for the right amount of information?
- ❑ Is your allotted time dedicated to more than just your information?
- ❑ Have you determined how much time you will need?
- ❑ Have you accounted for outside distractions?



Question about your atmosphere

- Will you be presenting in a large meeting room?
- Will you be in someone's office? Yours? Theirs?
- Will you be at a table?
- Are you training in a teleconference setting?
- Will you be standing in front of the group?
- Is food being served?
- Have you been to this room before?



The whole package

- Understand your presentation as it pertains to the group and your space.
 - Small group: Handouts vs. PowerPoint
 - Large group: Handouts and PowerPoint
 - One-on-one: Review handouts together
- Will you be providing take aways?
 - Do they need explained/reviewed?



How to get and keep the room's attention

- Voice tone and pitch
- Humor
- Planned pauses
- Breaks
- Questions throughout vs. at the end
- Ask questions of the audience



Now you're ready or are you?

- If time permits, practice.
 - Practice in front of a mirror
 - Time yourself
 - Record pieces of your presentation
 - Practice in the room you will be in if possible.
- What to wear?
- Make copies and check them for accuracy.
 - Collated properly
 - Clean copies

The day of...

- ❑ Don't drink excessively before you present.
- ❑ Check your appearance-hair, teeth, outfit, etc.
- ❑ Don't eat something that may be offensive to the front row.
- ❑ Take one more look at your presentation
- ❑ Arrive early
 - Introduce yourself to your host
 - Check equipment
 - Atmosphere/Temperature
 - Become comfortable with the room



During...



- Picture your audience in their underwear if you find yourself losing confidence.
- Look to the back row. Everyone will think you are looking at them, but you'll be more at ease as you'll be looking at no one.
- Take a break
 - The audience has fallen asleep
 - You have fallen asleep
 - You need to adjust something



And of course, after...

- Prepare an evaluation of you, your material, the room etc.
 - The speaker was informative.
 - The speaker presented in an orderly fashion
 - The room temperature
 - The material was...
 - The presentation was easy to follow
- If you were an invited speaker, consider sending a thank you note or a follow up letter.
- Determine what follow up your audience expects.
 - An audit/review
 - Another meeting at a defined time period
 - A bill



Do's and Don'ts

- Do speak slowly and clearly
- Do know the order of your presentation
- Do address the audience directly
- Do use examples pertinent to your audience
- Use your tools to your advantage
- Don't read from your slides
- Don't read from notes
- Don't talk to your slides
- Don't clutter your slides
- Don't provide your entire presentation on the slides

Questions



- Suzan Berman, CPC,
CEMC, CEDC
- AAPCCA Board of
Directors-Secretary
- Suzan.berman-
hvizdash@aapcca.org

- Senior Auditor
- ACE Med Web
- ACEMedWeb@gmail.com