APC Shared Billing in Trauma and Critical Care

Kyle L. Campbell, CPC
Senior Coding Consultant III, Ambulatory Coding and Reimbursement, Intermountain Healthcare; Salt Lake City, Utah

Mary Ruth Pugh, MSN, FNP-BC
Trauma Nurse Practitioner, Program Director of Trauma and Critical Care APC Postgraduate Residency, Intermountain Medical Center, Intermountain Healthcare; Salt Lake City, Utah

Objectives:
• Explain the multiple scenarios for how documentation can be used for billing and coding
• Describe risk areas that apply to billing and coding
• Review how to determine levels of service
APC Shared Billing in Trauma and Critical Care

Kyle Campbell, CPC
Mary Ruth Pugh, MSN,
FNP-BC
Collaborative practice between APC’s and Physicians

• Utilizing a collaborative practice between APC’s and Physicians is the best practice
• Physicians and APC’s both see patients. The physicians can utilize APC’s documentation to support their own billing for certain services
• APC’s can bill for services they provide independently
• Ideal model for patient care
Shared services

*Medicare Claims Processing Manual, Chapter 12*

- When a hospital inpatient/hospital outpatient or emergency department E/M is shared between a physician and an NPP from the same group practice and the physician provides any face-to-face portion of the E/M encounter with the patient, the service may be billed under either the physician's or the NPP's UPIN/PIN number.

- 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.
Shared services

The How of Shared visits

• An APC documents the service provided – typically includes a History, Exam and Medical Decision Making

• The physician makes their own note including the History, Exam he/she personally performed. The note must show they performed a face-to-face service

• The physician should not use a GME statement such as “I saw and examined the patient and agree with the assessment and plan as documented by __________, APC.
## Shared Services vs. Incident-to

<table>
<thead>
<tr>
<th>Shared Services</th>
<th>Incident-to</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital-based services</td>
<td>Clinic-based services (non hospital-based)</td>
</tr>
<tr>
<td>APC and Physician “share” notes for</td>
<td>Physician does not have to see the patient to use APC note for billing</td>
</tr>
<tr>
<td>billing</td>
<td></td>
</tr>
<tr>
<td>New patients and new problems</td>
<td>New patients and new problems cannot be reported incident-to</td>
</tr>
<tr>
<td>can be shared</td>
<td></td>
</tr>
</tbody>
</table>
Shared services

*Services that can be shared*

- Hospital-based evaluation and management services
  - Initial hospital care (H&P)
  - Subsequent hospital care (daily rounding)
  - Inpatient consultations
  - Observation services
  - Hospital-based clinic outpatient office visits
Shared services

*Services that cannot be shared*

- Minor procedures
- Services provided independent of a Physician when the physician does not have a face-to-face encounter with the patient
- Non-hospital based services
Shared services

Compliance requirements for Shared services

• The Physician and APC must be in the same group practice or employed in by the same entity
  • Shared services guidelines
  • Anti Kickback statute
• The APC must **not** be listed on the hospital cost-report
Example 1

________________________

____________,  PAC

Trauma Attending
I was present in the patient's room and actively participated in the trauma evaluation and workup of this patient. I obtained the history, performed an examination, reviewed all workup including labs and radiology data and I formulated the plan of care and discussed in detail with the RN, trauma team and documented in the above history and physical document to which I comprehensively contributed. I accepted the patient in transfer from the referring attending and was present upon his arrival. On my initial examination he was awake and alert. Following commands with all four extremities with a GCS of 15. He grossly had 5/5 strength in all fours. Midline cervical tenderness posteriorly and in a c-collar for immobilization. His chest, abdomen and pelvis were non-tender. His outside workup did reveal a C2 fracture and I have consulted the spine specialists on call - formal recs are pending. He does have some displacement and potential for instability is quite high. Additional workup including CT angio neck was negative. There is certainly potential for complications, additional injuries, morbidity, and internal bleeding. I plan admission for close monitoring, serial examinations, tertiary exam and additional workup as indicated. All questions answered.

________________________

______________________,  MD

Date:__________ Time:__________
Example 2

ADMISSION DIAGNOSES:
1. Trauma 1 full team activation, status post falling down the stairs.
2. Subarachnoid hemorrhage.
3. Cerebral edema.
4. Traumatic encephalopathy.
5. Fracture of ribs on the right side #2 through 6.
7. Suspected pneumonia, suspected right lower lobe.

HISTORY OF HOSPITALIZATION: Mr. Huffman is a 75-year-old male who per report had an unwitnessed fall down stairs at his home with a GCS score of 6, prompting transfer to Intermountain Medical Center as a trauma 1 full team activation. Please refer to history and physical for his initial workup. The patient was intubated and treated as traumatic brain injury in the shock trauma ICU. The patient was given hypertonic saline was ventilated per head injury protocols and had frequent neuro exams. Unfortunately, the patient's mental status did not improve be on a Glasgow Coma Score of 6. The patient also had a suspected ventilator acquired pneumonia and was started on vancomycin and Zosyn on February 8. With discussions between family and the trauma service and Neurosurgery, the family felt it was best to provide comfort care for the patient. The patient was extubated in shock trauma ICU and subsequently transferred to T11 with comfort care protocols. The patient expired at 0900. I could not auscultate heart sounds or palpate a pulse at that time. The family was present in the room. Social work is involved in disposition of the body, but it is my understanding that he will go to the medical examiner. Questions were answered for the family.

__________________________________________
__________________, PA-C

__________________________________________
__________________,  MD Date:__________ Time:__________
Example 3

Contributing Clinicians: ________________, PA-C, ________________, MD

**Supervising Physician Comments:** I have obtained an interval history and examined the patient, and evaluated the laboratory and imaging data. The patient's condition has been discussed today with other physicians, house staff and bedside personnel in detail to assure best possible care. I have read and reviewed the above note. Patient seen and examined at bedside. History, exam and data reviewed. Plan formulated together. As the attending physician, I personally met with the patient and/or family and discussed the patient's status. no change in mental status.. needs to mobilize. will not restart Coumadin. resume diet. can transfer from ICU.

Lab values displayed as *** or blank with timestamp should be reviewed in the Lab Module
Help Data retrieval Thu Feb 13 08:05:18 MST 2014
CDR Data retrieval Thu Feb 13 09:48:06 MST 2014

Supplemental Information:
CPT-EM code: 99233 Subsequent Inpatient

**Authored By:** ________________, PA-C
**Authored For:** ________________, MD
**Electronically Signed By:** ________________, MD (02/17/14 (14:55))
Example 4

Procedure: Endotracheal Intubation

Hospital Location: IMC STICU
Emergent? YES

Reason For Procedure: Hemorrhagic Shock

Consent: Either verbal or written consent was obtained and the benefits and risks of the procedure were discussed with either the patient or family member as the situation allowed.

Procedure Performed By:
Attending: ________________, MD
Resident: ______________
APC: ________________, PA-C

Procedure:
The patient was placed in the supine position, and received 100% oxygen via face mask and a respiratory therapist was present to assist and suction was at the patient's bedside. The following medication(s) were used for sedation and for induction: Ketamine and the following paralytics for induction Vecuronium. A size FOUR Glide scope blade was used. Upon inspection, the patient had a grade TWO Mallampati score and a grade ONE airway visualization. The laryngoscope was placed and a size EIGHT tube was passed with good visualization. The balloon was inflated using a 10cc syringe.

Number of Attempts: 1

Complications: None

Assessment:
Patient tolerated procedure well.
Humidification of the Tube YES
Auscultative Sounds: BS cta
Post Intubation Co2: 31
Post Intubations Portable Chest CT will be taken for placement see associated film.

Authored By: ________________, PA-C
Authored For: ________________, MD
Electronically Signed By: ________________, MD (04/20/14 (07:26))
DISCHARGE DIAGNOSES:
1. Trauma consultation, ground level fall.
2. C7 fracture.

HOSPITAL COURSE: For complete details of admission, please see history and physical, which is dated _______, 2014. However, briefly, this is an 89-year-old female with a history of multiple falls who unfortunately had another fall onto concrete. This was mechanical in nature. She has baseline dementia. She was found to have the above listed C7 fracture and was admitted to the 11th floor for appropriate consultation with spine surgery and pain management. Dr. ____________ was consulted and his recommendations included cervical collar as treatment for her fracture. A thorough tertiary exam was performed and did not identify any further injuries. The patient was found to be at her baseline of mild confusion secondary to chronic dementia. She did require a patient safety advocate outside of the room, primarily for some agitation surrounding her cervical collar. She was up with physical therapy and occupational therapy and met her goals from this standpoint. She had her pain well controlled with oral opioid analgesia. She was discharged on __________, 2013, with the following discharge instructions.

DISCHARGE INSTRUCTIONS:
1. Discharge to skilled nursing facility, Highland Care.
2. Follow up with Dr. ____________ at phone _________ in 1-2 weeks with repeat C-spine x-rays.
3. Physical therapy and occupational therapy to continue to evaluate and treat with the only activity restriction being cervical collar at all times.
4. Medication reconciliation was provided for the skilled nursing facility and include the patient’s home medication regimen as well as Lovenox 30 mg subcu b.i.d. x1 week.
5. Other discharge medications and prescription was inclusive for oxycodone 5 mg 1 tablet p.o. q.4 hours p.r.n. severe pain.

The patient and the family were amenable to this plan of discharge and understood the above outlined plan.

Dr. ____________ was the attending trauma surgeon on the day of discharge and they are in agreement with the above listed discharged plan.

_____________ PA-C

_____________ MD

Date:__________ Time:__________

Authored By: ____________, PA-C
Authored For: ____________, MD
Electronically Signed By: ____________, MD (04/23/14 16:52)
Example 6

- **DATE-TIME:** 6:21 PM

- **NOTES:**

  **Gen Surgery**

  5: PM: reports headache and back pain (same) over the last several hours. She reports fever, chills, and N/V. She states that she has been having some urine output since the last meal due to use of catheter.

  **O:** 84/132, HR 107, RR 25, T 37.4

  - A: 37-38
  - T: 37
  - W/BS: 13.2
  - CRAB:
    - E: R: 30
    - BP: 130/80
    - P: 30-35
    - S: 18
  - ext: recumbent, F/E/R
    - Labs & imaging reviewed.

  **VP:** Discussed with the son about the patient's serious condition post-vertebroplasty surgery. We explained to her that she would likely be in the hospital longer, but had a high chance of multiple surgeries. She was advised to undergo the procedure.

  **A:** 79 yo, gait dx of prior stroke, malnutrition, and multiple other complications that point to evidence of previous deep vein thrombosis.

  **P:**
    - Exop.: Poss bowel resection, poss ostomy vs. non op reg
    - Called so. to come to the hospital for further discussion.
    - Will proceed with discussion.

  **Gen Surgery: able to lie down and ambulate, ambulated to bathroom, no further issues noted.**
Example 7

Surgery Progress Note

VTE Prophylaxis: None / SCG's / LMWH
Subcutaneous Heparin / Warfarin / Xa Inhibitor
Enabled to use Enoxaparin due to:
- Vertebral Fr. C7, T1, T2, T4: Non-op.
- c-collar status
- PPI or again today
- cont. c-collar

Rib Fr. R 6+7
- cont. 15
- ambulation

Cellulitis, R lower leg
- cont. Bacitracin + moxiflox today
- cont. Bacitracin + moxiflox with 3 day Ketek to complete
- D/c with 3 day Bacitracin

Diet - full diet w/ supervision
- cont. enoxaparin, SCG
- cont. enoxaparin, RX to SNF

HTN: Improved on home meds (HCTZ + propranolol)
- cont. home meds

Dispo. To SNF today

Agitation: Given seroquel + Halol
Oversed with good relief
Measurable to continue seroquel
GTS, d/c with RX

6U. D/C Foley, place brief/bedpan
PEN.

Trauma Surgery Attending

Date:
Time:
The patient was examined and discussed with housestaff.
I agree with the plan.

MD

[Signature]

[Signature]
Example 8

Surgery Progress Note
NAME: FISHER, AMY ROBERT
NO: 215011263
ROOM: 1126
SHIFT: FEB 13 09:38 - FEB 14 06:22
Page: 3
No VTE prophylaxis mechanical or pharmacological is indicated for low risk alert patients.

Note: If the physician has ordered VTE prophylaxis, this VTE Risk assessment does not override the physician order and the physician order must still be administered timely.

Note: This risk assessment does not necessarily apply to SSI and Stroke patients who require a specific review of VTE prophylaxis beyond the minimum guidelines for all inpatients.

--------------- CARE COORDINATION PHYSICIAN COMMUNICATION -----------------------------

Date and Time of Anticipated Discharge / Transfer (Circle Discharge or Transfer): ________________

Discharge / Transfer Location: __Home__ / ER / Rehab / Home with DME / Homecare / Other: ________________

Top Criteria / Issues for Patient to Reach Discharge / Transfer Readiness:
(Example: Discontinue TPN or IV Antibiotics, Discontinue Foley, Use bathroom, Tolerate oral medications, PT needs assessed)


Physician Contact Name: _____________________________
Number: ___________________________

ASSessment / PLAN: (Circle/Check all that apply)

Urinary Catheter: Date Inserted: ___________________________
Maintain Catheter due to following Condition(s): ________________

[ ] Acute urinary retention or obstruction
[ ] Comfort care for the end of life
[ ] Patient requires prolonged immobilization
[ ] Chronic Catheterization
[ ] Strict I&O Monitoring

VTE Prophylaxis: None / SCF's / LMW Subcutaneous Heparin / Warfarin / Antiplatelet
Unable to use Pharmacoprophylaxis due to:

1. CRF/Atib - seen by cardiologist on 2-11 - will fly in their clinic
   when discharged. Can't reprocess, re-admit a 6 day. (G)
   2. Effusion - chest tube pulled yesterday, CRF pending
      this morning.

signature: _____________________________  Date: ____________  Time: ____________

Trauma Surgery Attending
Date: ____________  Time: ____________
The patient was examined and discussed with housestaff. I agree with their plan.

__________________________  MD
Example 9

19416
WSGY Procedure:
Placement external ventricular drain for intracranial pressure monitoring/drainage
Complications: None
EBL: 200 mL
Mr. Krish MD, M Smith RN
Bioglides catheter placed, left 2 cm H2O
clear CSF returned. CT Scan 1700 shows adequate placement
of catheter.
Evaluation and Management Levels

Choose “add title slide” from the formatting palette for chapter slides
# Evaluation and Management coding

## Office/Outpatient Evaluation and Management Services

<table>
<thead>
<tr>
<th>1. Select type of</th>
<th>Straightforward</th>
<th>Straightforward</th>
<th>Low</th>
<th>Moderate</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life/limb threatening, severe exacerbation, parenteral controlled substance</td>
<td>1 HPI</td>
<td>1 System Exam</td>
<td>2 HPI, 1 ROS, 1 PFSH</td>
<td>4 HPI, 10 ROS, 3 PFSH</td>
<td>4 HPI, 10 ROS, 3 PFSH</td>
</tr>
<tr>
<td>New Pt. Office</td>
<td>99201 (10min)</td>
<td>99202 (20min)</td>
<td>99203 (30min)</td>
<td>99204 (45min)</td>
<td>99205 (60min)</td>
</tr>
<tr>
<td>Office Consult</td>
<td>99241 (15min)</td>
<td>99242 (30min)</td>
<td>99243 (40min)</td>
<td>99244 (60min)</td>
<td>99245 (80min)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Determine Medical Decision-Making</th>
<th>Straightforward</th>
<th>Straightforward</th>
<th>Low</th>
<th>Moderate</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Threatening, undiagnosed with limited prob (e.g., cold, insect bite, tinea corporis, minimal lab tests, rest)</td>
<td>1 HPI</td>
<td>1 System Exam</td>
<td>2 HPI, 1 ROS, 1 PFSH</td>
<td>4 HPI, 10 ROS, 3 PFSH</td>
<td>4 HPI, 10 ROS, 3 PFSH</td>
</tr>
<tr>
<td>Nurse's Visit</td>
<td>See Medical Group Policy</td>
<td>1 HPI</td>
<td>1 System Exam</td>
<td>2 HPI, 1 ROS</td>
<td>4 HPI, 2 ROS, 1 PFSH</td>
</tr>
<tr>
<td>Est. Pt. Office</td>
<td>99211 (5min)</td>
<td>99212 (10min)</td>
<td>99213 (15min)</td>
<td>99214 (25min)</td>
<td>99215 (40min)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. Obtain hx/ex</th>
<th>Straightforward</th>
<th>Straightforward</th>
<th>Low</th>
<th>Moderate</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life/limb threatening, severe exacerbation, parenteral controlled substance</td>
<td>1 HPI</td>
<td>1 System Exam</td>
<td>2 HPI, 1 ROS, 1 PFSH</td>
<td>4 HPI, 10 ROS, 3 PFSH</td>
<td>4 HPI, 10 ROS, 3 PFSH</td>
</tr>
<tr>
<td>Nurse's Visit</td>
<td>See Medical Group Policy</td>
<td>1 HPI</td>
<td>1 System Exam</td>
<td>2 HPI, 1 ROS</td>
<td>4 HPI, 2 ROS, 1 PFSH</td>
</tr>
<tr>
<td>Est. Pt. Office</td>
<td>99211 (5min)</td>
<td>99212 (10min)</td>
<td>99213 (15min)</td>
<td>99214 (25min)</td>
<td>99215 (40min)</td>
</tr>
</tbody>
</table>

## Inpatient Evaluation and Management Services

<table>
<thead>
<tr>
<th>1. Select type of</th>
<th>Straightforward</th>
<th>Straightforward</th>
<th>Low</th>
<th>Moderate</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life/limb threatening, severe exacerbation, parenteral controlled substance</td>
<td>1 HPI</td>
<td>1 System Exam</td>
<td>2 HPI, 1 ROS, 1 PFSH</td>
<td>4 HPI, 10 ROS, 3 PFSH</td>
<td>4 HPI, 10 ROS, 3 PFSH</td>
</tr>
<tr>
<td>Initl Hospital Care</td>
<td>99251 (20min)</td>
<td>99252 (40min)</td>
<td>99253 (55min)</td>
<td>99254 (80min)</td>
<td>99255 (110min)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Determine Medical Decision-Making</th>
<th>Straightforward</th>
<th>Straightforward</th>
<th>Low</th>
<th>Moderate</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Threatening, undiagnosed with limited prob (e.g., cold, insect bite, tinea corporis, minimal lab tests, rest)</td>
<td>1 HPI</td>
<td>1 System Exam</td>
<td>2 HPI, 1 ROS, 1 PFSH</td>
<td>4 HPI, 10 ROS, 3 PFSH</td>
<td>4 HPI, 10 ROS, 3 PFSH</td>
</tr>
<tr>
<td>Nurse's Visit</td>
<td>See Medical Group Policy</td>
<td>1 HPI</td>
<td>1 System Exam</td>
<td>2 HPI, 1 ROS</td>
<td>4 HPI, 2 ROS, 1 PFSH</td>
</tr>
<tr>
<td>Est. Pt. Office</td>
<td>99211 (5min)</td>
<td>99212 (10min)</td>
<td>99213 (15min)</td>
<td>99214 (25min)</td>
<td>99215 (40min)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. Obtain hx/ex</th>
<th>Straightforward</th>
<th>Straightforward</th>
<th>Low</th>
<th>Moderate</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life/limb threatening, severe exacerbation, parenteral controlled substance</td>
<td>1 HPI</td>
<td>1 System Exam</td>
<td>2 HPI, 1 ROS, 1 PFSH</td>
<td>4 HPI, 10 ROS, 3 PFSH</td>
<td>4 HPI, 10 ROS, 3 PFSH</td>
</tr>
<tr>
<td>Nurse's Visit</td>
<td>See Medical Group Policy</td>
<td>1 HPI</td>
<td>1 System Exam</td>
<td>2 HPI, 1 ROS</td>
<td>4 HPI, 2 ROS, 1 PFSH</td>
</tr>
<tr>
<td>Est. Pt. Office</td>
<td>99211 (5min)</td>
<td>99212 (10min)</td>
<td>99213 (15min)</td>
<td>99214 (25min)</td>
<td>99215 (40min)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4. Report code</th>
<th>Straightforward</th>
<th>Straightforward</th>
<th>Low</th>
<th>Moderate</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life/limb threatening, severe exacerbation, parenteral controlled substance</td>
<td>1 HPI</td>
<td>1 System Exam</td>
<td>2 HPI, 1 ROS, 1 PFSH</td>
<td>4 HPI, 10 ROS, 3 PFSH</td>
<td>4 HPI, 10 ROS, 3 PFSH</td>
</tr>
<tr>
<td>Nurse's Visit</td>
<td>See Medical Group Policy</td>
<td>1 HPI</td>
<td>1 System Exam</td>
<td>2 HPI, 1 ROS</td>
<td>4 HPI, 2 ROS, 1 PFSH</td>
</tr>
<tr>
<td>Est. Pt. Office</td>
<td>99211 (5min)</td>
<td>99212 (10min)</td>
<td>99213 (15min)</td>
<td>99214 (25min)</td>
<td>99215 (40min)</td>
</tr>
</tbody>
</table>

## Subs. Hsptl. Care

<table>
<thead>
<tr>
<th>1. Patient is typically stable, responding well to treatment, problems resolving</th>
<th>1 HPI</th>
<th>1 System Exam</th>
<th>2 HPI, 1 ROS, 1 PFSH</th>
<th>4 HPI, 10 ROS, 3 PFSH</th>
<th>4 HPI, 10 ROS, 3 PFSH</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Patient is typically stable, but still requires a considerable amount of care to manage their multiple problems</td>
<td>1 HPI</td>
<td>1 System Exam</td>
<td>2 HPI, 1 ROS, 1 PFSH</td>
<td>4 HPI, 10 ROS, 3 PFSH</td>
<td>4 HPI, 10 ROS, 3 PFSH</td>
</tr>
<tr>
<td>3. Patient is typically unstable, continues to develop new problems or respond poorly to treatment</td>
<td>1 HPI</td>
<td>1 System Exam</td>
<td>2 HPI, 1 ROS, 1 PFSH</td>
<td>4 HPI, 10 ROS, 3 PFSH</td>
<td>4 HPI, 10 ROS, 3 PFSH</td>
</tr>
</tbody>
</table>

### Lift & Hospital Services

<table>
<thead>
<tr>
<th>1. Lift &amp; Hospital Services</th>
<th>2. Lift &amp; Hospital Services</th>
<th>3. Lift &amp; Hospital Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life/limb threatening, severe exacerbation, parenteral controlled substance</td>
<td>Life/limb threatening, severe exacerbation, parenteral controlled substance</td>
<td>Life/limb threatening, severe exacerbation, parenteral controlled substance</td>
</tr>
</tbody>
</table>
Evaluation and Management continued

<table>
<thead>
<tr>
<th>History</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>History of Present Illness (HPI)</strong></td>
</tr>
<tr>
<td><strong>Location:</strong> Where symptom is occurring (e.g., ulcer on hand, GERD, abdominal pain)</td>
</tr>
<tr>
<td><strong>Quality:</strong> e.g., pressure, crushing, sharp, dull, etc.</td>
</tr>
<tr>
<td><strong>Severity:</strong> Rank of symptom/pain (mild to severe)</td>
</tr>
<tr>
<td><strong>Duration:</strong> Onset of complaints to present (e.g., one week, 24 hours, six months, etc.)</td>
</tr>
<tr>
<td><strong>Context:</strong> Situation associated with symptom/pain (e.g., it hurts when I do this, increases with dairy products, etc.)</td>
</tr>
<tr>
<td><strong>Mod. Factors:</strong> Measures taken to alleviate symptom (e.g., over the counter cough syrup, advil, etc.)</td>
</tr>
<tr>
<td><strong>Assoc. S/S:</strong> Concurrent with the patient’s chief complaint</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Review of Systems (ROS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Constitutional</td>
</tr>
<tr>
<td>• Eyes</td>
</tr>
<tr>
<td>• ENT, Mouth</td>
</tr>
<tr>
<td>• Cardiovascular</td>
</tr>
<tr>
<td>• Respiratory</td>
</tr>
<tr>
<td>• Gastrointestinal</td>
</tr>
<tr>
<td>• Musculoskeletal</td>
</tr>
<tr>
<td>• Endocrine</td>
</tr>
<tr>
<td>• Genitourinary</td>
</tr>
<tr>
<td>• Neurological</td>
</tr>
</tbody>
</table>

| All Others Reviewed and are Negative |

<table>
<thead>
<tr>
<th>Past, Family, Social History (PFSH)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Past History</strong></td>
</tr>
<tr>
<td>consists of statements concerning the patient’s past medical history, such as, current medications, prior surgeries, hospitalizations, illnesses, injuries, allergies, immunizations, etc.</td>
</tr>
<tr>
<td><strong>Social History</strong></td>
</tr>
<tr>
<td>consists of statements related to the patient’s social life, such as, marital status, work, drug and alcohol, tobacco, sexual history, education, etc.</td>
</tr>
<tr>
<td><strong>Family History</strong></td>
</tr>
<tr>
<td>consists of statements concerning the health status (past and present) or cause of death of the patient’s family members.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Examination</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Body Areas</strong></td>
</tr>
<tr>
<td><strong>Organ Systems</strong></td>
</tr>
<tr>
<td><strong>Head/Face</strong></td>
</tr>
<tr>
<td>• Eyes</td>
</tr>
<tr>
<td>• ENT, Mouth</td>
</tr>
<tr>
<td>• Cardiovascular</td>
</tr>
<tr>
<td>• Abdomen</td>
</tr>
<tr>
<td>• Genitalia, Groin</td>
</tr>
<tr>
<td>• Back, Spine</td>
</tr>
<tr>
<td>• Each Extremity</td>
</tr>
<tr>
<td>• Constitutional (e.g., Vitals, Gen. Appearance)</td>
</tr>
<tr>
<td><strong>Neck</strong></td>
</tr>
<tr>
<td>• Neurological</td>
</tr>
<tr>
<td>• Respiratory</td>
</tr>
<tr>
<td>• Lymph/Heme/Immun</td>
</tr>
<tr>
<td><strong>Chest, Breasts</strong></td>
</tr>
<tr>
<td><strong>Gastrointestinal</strong></td>
</tr>
<tr>
<td><strong>Integumentary</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Time Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>The following must be documented in either the paper chart or in the electronic medical record.</td>
</tr>
<tr>
<td>1. The total amount of time spent providing care to the patient on the floor or unit.</td>
</tr>
<tr>
<td>2. That greater than 50% of the time spent was in counseling and coordination of care.</td>
</tr>
<tr>
<td>3. What that counseling/coordination of care was in reference to.</td>
</tr>
</tbody>
</table>
References

CMS Manual System Pub 100-4 Transmittal 2282

Medicare Claims Processing Manual, Chapter 12 – Physicians/Nonphysician Practitioners

1995 DOCUMENTATION GUIDELINES FOR EVALUATION AND MANAGEMENT SERVICES
Questions?

Kyle Campbell, CPC – 801-442-1312
Kyle.campbell@imail.org

Mary Ruth Pugh, MSN, FNP-BC