

Physician Practice E/M Guidelines

Audio Seminar/Webinar *November 10, 2009*

Practical Tools for Seminar Learning

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Presentation Objectives

- Discuss and compare 1995 and 1997 guidelines
- Summarize documentation requirements
- Explain how to determine which documentation guidelines are more advantageous to the physician
- Time-based E/M coding
- Medical necessity

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General Documentation Principles

- The medical record should be complete and legible
- Documentation of each patient encounter should include:
 - reason for the encounter and relevant history, physical examination findings and prior diagnostic test results
 - assessment, clinical impression or diagnosis
 - plan for care
 - date and legible identity of the observer

General Documentation Principles

- Reason for ordering tests and ancillary services should be documented or easily inferred
- Past and present diagnoses should be accessible
- Health risk factors should be identified
- The patient's progress, response to and changes in treatment, and revision of diagnoses should be documented
- The CPT and ICD-9-CM codes reported should be supported by the documentation

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Medical Necessity

- Medical necessity is the overarching criterion for payment in addition to the individual requirements of a CPT code (CMS Manual, Publication 100-4, Chapter 12, Section 30.6.1)
- The chief complaint, reason for the visit or presenting problem establishes medical necessity and the reasonableness of the service
- Caveat: EHR and other templates make it easy to document comprehensive levels of history and exam – Is it necessary?

Medical Necessity - Example

- A young otherwise healthy established patient presents to the office with sprained ankle
- Physician performs a comprehensive history and a head-to-toe exam
- Should a 99215 be coded?
- Was a comprehensive history and exam necessary?

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Volume of Documentation

- The volume of documentation is not the sole indication for a level of service
- Documentation that meets guidelines for a given level of service (LOS) but is excessive for the treatment of the patient may not be considered when assigning a visit level
- Assign E/M level based upon the relevant history, exam and medical decision making

Varying E/M Documentation Guidelines

- Follow documentation guidelines, scoring, etc. for your local carrier/Medicare Administrative Contractor (MAC)
- Check third party payer websites and manuals for variations
 - In absence of written requirements to the contrary, most will accept Medicare's because they are considered the "gold standard"

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Evaluation and Management Overview

- 3-5 levels of service within each E/M category or subcategory
 - New vs. established patient
 - Initial vs. subsequent
 - Place of service (POS) dependent
- Requirements not interchangeable between categories
- Consider patient type, POS and E/M category before assigning E/M code

E/M Services Contain 7 Components

- History
- Physical Exam
- Medical Decision Making



- Counseling
- Coordination of Care
- Nature of the Presenting Problem
 - Establishes medical necessity
- Time
 - Controlling factor only when visit dominated by counseling and/or care coordination

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Key Components

- All 3 key components need to be met or exceeded for:
 - New patient visits office/outpatient visits, home visits, domiciliary care
 - Consultations
 - Initial inpatient, initial observation, initial nursing facility care
 - Annual nursing facility assessments
 - Emergency Department visits

Key Components

- 2 key components need to be met or exceeded for:
 - Established patient visits –
 office/outpatient, home, domiciliary care
 - Subsequent inpatient care and subsequent nursing facility care

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History Element

- Information is obtained from patient
- Subjective findings
- Contains 3 components
 - HPI History of Present Illness
 - ROS Review of Systems
 - PFSH Past, family and social history
 - Note: in order to qualify for a given type of history, all three elements must qualify for that level

History of Present Illness

- Chronological description of patient's present illness from onset to present
- HPI includes the following elements:
 - Location (e.g. neck, abdomen)
 - Quality (e.g. sharp, burning)
 - Severity (e.g. pain scale 1-10)
 - Duration (e.g. "had it for two weeks")
 - Timing (e.g. worse at night)
 - Context (e.g. comes and goes)
 - Modifying factors (e.g. worse when sitting)
 - Associated signs and symptoms

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History of Present Illness

- Two levels of HPI brief and extended
 - Brief contains one to three elements
 - Extended contains four or more elements
 - Example: Documentation states that the patient has had abdominal pain she describes as "sharp for 3 days." The medical record also states she has taken aspirin with no relief, she describes the pain as a 7 on a scale of 1 to 10 and that it is worse at night.

There are 6 elements of HPI in this example – location (abdomen), quality (sharp), severity (pain scale), duration (three days), modifying factors (no relief from medication) and timing (worse at night). Therefore this HPI is extended.

History of Present Illness

- 1997 Guidelines allowed one other criteria to be used for an extended HPI.
- If 3 or more chronic conditions are also listed, the HPI would be considered extended.
- Some CMS carriers allow the status of 3 or more chronic conditions as an extended HPI with 1995 exam.

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Review of Systems

- Definition: Inventory of body systems obtained through a series of questions
- 14 different systems are recognized, including constitutional symptoms such as fever or weight loss.
- 3 levels of ROS
 - Problem pertinent directly related to the problems identified in the HPI.
 - Extended Problems in HPI, plus a limited number of additional systems
 - Complete All systems.

Past, Family and Social History

- Like other elements in History, obtained directly from patient
- Both ROS and PFSH may be obtained by directly asking patient or from a pre-printed questionnaire.
 Provider should initial/sign/refer to
- Use only family history pertinent to patient's current condition. (i.e. if pt presents with chest pain, father's history of MI is pertinent, mother's GYN history is not)
- Level of PFSH depends on how many of these three elements are documented.

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Examination 1995 vs. 1997

- 1995
 - Vague, interpretive, less precise
 - Subjective; auditors often disagree on how to count body areas/organ systems
- 1997
 - General Multisystem Exam
 - Eleven Single System Specialty Exams
 - Contain bulleted exam elements
 - Count the bullets for exam level

1995 Body Areas (BA) for Exam

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

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1995 Organ Systems (OS) for Exam

- Constitutional (not recognized by CPT®)
- Eyes
- Ears, nose, mouth, throat
- Cardiovascular
- Respiratory
- Gastrointestinal

1995 Organ Systems for Exam

- Genitourinary
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Hematologic/lymphatic/immunologic

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Four Levels of Examination (1995)

- Problem Focused (PF)— 1 organ system or body area
- Expanded Problem Focused (EPF)
 2-7 organ systems and/or body areas
 (OK to mix or match, but no double dipping)
- Detailed (D)

 2-7 organ systems and/or body areas
 (OK to mix or match, but no double dipping)
- Comprehensive (C)

 complete multisystem exam (8 or more organ systems) or a comprehensive exam of a single organ system (undefined)

What's the Difference Between an EPF and a Detailed Exam (1995)?

- Subjective depends upon clinical knowledge of auditor
- Both include exam findings for 2-7 OS/BA
- Expanded problem focused exam requires a limited exam of the affected BA/OS and includes findings for an additional related 1-6 BA/OS

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What's the Difference Between an EPF and a Detailed Exam (1995)?

- Detailed exam requires an extended exam of the affected BA/OS and includes findings for an additional 1-6 other related BA/OS
- Exam should be relevant to the chief complaint or presenting problem
- Never count the same exam element as both OS and BA – no double dipping

11 Single System Examinations (1997)

- Cardiovascular
- Ears, Nose, Mouth and Throat
- Eyes
- Genitourinary Male
- Genitourinary Female
- Hematologic/Lymphatic/Immunologic

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11 Single System Examinations (1997)

- Musculoskeletal
- Neurological
- Psychiatric
- Respiratory
- Skin

Multisystem Examination (1997)

- Count the exam elements identified by a bullet
 - 1−5 elements = Problem Focused (PF)
 - 6-11 elements = Expanded Problem Focused (EPF)
 - ≥ 2 elements from any 6 areas/systems
 or ≥ 12 from ≥ 2 areas/systems
 = Detailed (D)
 - ≥ 2 bullets from at least 9 areas/systems
 = Comprehensive (C)

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Single System Examination (1997)

- Count the exam elements identified by a bullet
 - 1–5 elements = Problem Focused (PF)
 - 6-11 elements = Expanded Problem Focused (EPF)
 - At least 12 elements = Detailed (D)
 - Exception: Eye and Psych = 9 bullets (single organ system)
 - Perform all bulleted elements. Document all elements in boxes with shaded borders and at least one element in boxes with unshaded borders
 Comprehensive (C)

Examination - 1995 vs. 1997?

- CMS states that either 1995 or 1997 guidelines may be used – whichever is most advantageous to the provider
- Frequently the 1995 guidelines benefit providers
- Specialists may prefer 1997 guidelines
- Be sure to identify any specific payer guidelines that differ
- Exam myth: You must pick one or the other and use it for all patients

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Example

Established Patient Office Visit

Chief Complaint: Follow-up HTN

Exam: Awake, alert, NAD BP 158/78, HR 56, RR 20

Lungs: CTA

Heart: RRR, no MRGs

No peripheral edema

Courtesy of Peter Jensen, MD www.EMuniversity.com

Example Established Patient Office Visit

- Qualifies as a problem focused (PF) exam using the 1997 E/M guidelines based on the documentation of the following five bullets: general appearance, three vital signs, auscultation of the lungs, auscultation of the heart and assessment of lower extremities for edema.
- Qualifies as an expanded problem focused (EPF) exam using the 1995 E/M guidelines based on the fact that three organ systems (constitutional, cardiovascular, and respiratory) are examined.

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Example Initial Psych Inpatient Exam

- Vitals 120/80 BP, Temp 99.0, pulse 76 per min (from nursing note)
- Appearance Neat
- Attitude Cooperative
- Psychomotor activity Appropriate
- Speech normal
- Affect appropriate
- Mood anxious
- Thought process goal directed
- Cognitive Function memory intact, alert, average intelligence
- No SI/HI, danger to self or others
- Insight intact, not impulsive
- Normal gait

Example - Psych 1995

 Meets expanded problem focused (EPF) level – system related to the problem (psych) and two additional systems (constitutional, musculoskeletal)

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Example - Psych 1997

- For psychiatric exam, meets both bullets for constitutional (three vital signs, appearance), one bullet for musculoskeletal (gait) and eight bullets for psychiatric exam.
- Total of 11 bullets detailed exam.
 Not comprehensive because not all bullets were documented in constitutional and psychiatric.

Medical Decision Making (MDM)

- Refers to the complexity of establishing a diagnosis and/or selecting a management option
- Three elements used
 - Number of possible diagnoses or management options
 - Amount/complexity of data reviewed
 - Risk of complication/morbidity/mortality

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MDM — **Diagnoses or Management**

- This is based on the number and types of problems encountered, complexity of establishing a diagnosis, and management decisions made.
- Generally, it is easier to make decisions on an established condition over a new one, and those that are stabilizing or improving over those that are worsening.

MDM — **Diagnoses or Management**

- NHIC uses a point system to determine the level of this element
 - One point each for self-limited, minor, or improving problem, up to two per case
 - Two points for each worsening problem, up to two per case
 - Three points for a new problem with no add'l workup planned
 - Four points for a new problem with add'l workup planned

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MDM — **Diagnoses or Management**

- The number of points assigned correspond to the four levels of diagnosis or management options
 - 1 point or less minimal
 - 2 points limited
 - 3 points multiple
 - 4 points or more extensive

MDM — Amount of Data

- Based on types of diagnostic testing ordered or reviewed, review of old medical records, and whether information was obtained from other sources.
- May also include discussion w/ provider who ordered test or independent review of tests, such as reading films instead of just reviewing other MD's findings.

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MDM — **Amount of Data**

- Points for different types of tests or data
 - 1 point each for labs, radiology and medicine. Number in each category doesn't matter -1 point for category
 - Discuss w/ other MD, order old record
 1 point
 - Review old records, independent review of test results – 2 points

MDM — Amount of data

- Same four categories with same point values as number of diagnoses.
 - Use as a guide, but let common sense prevail
 - Not always a fair measurement of intensity (e.g., should many x-rays, CT scans, MRI's, ultrasounds, etc. be the same amount of points (1) as one two view CXR?)

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MDM — **Risk**

- Risk of significant complications, morbidity and/or mortality
 - Based on the nature of the presenting problems, diagnostic procedures ordered and the management options selected
 - 4 levels minimal, low, moderate or high
 - Table of Risk gives examples

MDM — Table of Risk Guide

Risk level	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Mgmt Options Selected
Min	Self limited or minor	Lab tests, CXR, EKG, echo	RICE, superficial
	i.e. cold, bug bite		dressings
Low	2 + minor problems	Pulm function tests	OTC drugs, minor
	1 stable chronic illness i.e. HTN	Non-cardio imaging, i.e., barium enema	Surgery, physical therapy
Mod	Chronic illness w/ exac, 2 stable or 1 comp. illness/inj.	Dx endoscopies, Deep needle or incisional Bx, cardiac cath,	Elective maj. Surg Pres. Drug mgmt, Nuc, med
High	Chronic illness w/ severe exac, injury	Cardiovascular imaging studies w/ risk factors,	Ele. Maj. Surg w/risk, emer surgery
	or illness posing threat to life, abrupt neuro change (TIA)	Diagnostic endoscopies w/ risk factors, discography	Parenteral cont. substance, drug tx w/ monitoring

MDM — Table of Risk

- This table provides examples of what constitutes the various levels of risk. Use as a guide to find the risk level given the documentation being reviewed.
- Only one of the three criteria of risk needs to be met to assign that level.
- Use common sense MDM should be comparable to the diagnosis being treated (e.g., pharyngitis would not have high MDM).

Putting It All Together

- Now that we have seen how the three key elements of history, exam and medical decision making are documented, how is the E/M code determined?
- Remember the information we determined before reviewing the documentation: is this a new or established patient, and where was the service performed?
- Find the correct category in the E/M section of CPT that corresponds with the patient status and place of service.

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Putting It All Together

- Within that category, locate the code(s) that match the levels of the key elements that you have just determined.
- If a new patient, the key elements much match 3 of the 3 levels. For established patients, 2 of 3.
- If a key element meets the criteria for the highest level, it also will meet criteria for all lower levels (e.g., a detailed exam will meet criteria for a problem focused or expanded problem focused exam).

Example

Established Patient Office Visit

CC: F/U HTN

INTERVAL HISTORY: The patient's HTN remains labile and moderately severe with systolic readings occasionally in the 160s. There has been mild improvement with low sodium diet. Denies any associated symptoms such as pounding headaches or chest pain.

ROS: CV: Negative for CP or PND. EYES: Negative for blurry vision

PFSH is remarkable for dyslipidemia

Exam: Awake, alert, NAD. BP 158/78, HR 56, RR 20. Lungs CTA. Heart: RRR, no MRGs. No peripheral edema.

Labs: Creatinine 1.0, K 4.2, Hgb 13.4, LDL 77

Example is courtesy of Peter Jensen, MD at www.EMuniversity.com

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Example

Established Patient Office Visit

IMPRESSION:

- 1. Worsening HTN.
- 2. Stable hyperlipidemia.

PLAN:

- 1. Increase AMLODIPINE from 5 mg to 10 mg PO QD.
- 2. Continue low sodium diet.
- 3. BP check in two weeks.
- 4. Continue SIMVASTATIN.
- 5. RTC in three months with the usual labs.

Example Established Patient Office Visit

- quality (labile)
- severity (moderately severe)
- modifying factors (mild improvement with low sodium diet)
- associated signs and symptoms (denies associated symptoms...)
- This adds up to four HPI elements which qualifies as an extended HPI

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Established Patient Office Visit

Review of Systems & PFSH

- HPI = Extended (from previous slide)
- ROS = Extended (2 9 systems reviewed)
 - CV: Negative for CP or PND
 - EYES: Negative for blurry vision
- PFSH = Pertinent (1 element of PFSH)
 - Remarkable for dyslipidemia

Established Patient Office Visit

Determine the Level of History

History	HPI	ROS	PFSH
Problem Focused	Brief	None	None
Expanded Problem Focused	Brief	1	None
Detailed	Extended	2-9	1/3
Comprehensive	Extended	2-9	2/3

Established Patient Office Visit

Determine Level of Exam

- 1997 Guidelines = PF 5 bullets
 - general appearance
 - three vital signs
 - auscultation of the lungs
 - · auscultation of the heart
 - assessment of lower extremities for edema
- 1995 Guidelines = EPF limited exam of affected organ system and other related organ systems
 - Cardiovascular = affected organ system
 - Respiratory and constitutional = related systems

Established Patient Office Visit

Determine Level of MDM Points for

Diagnoses/Management Options & Data

- Number of Diagnoses/Mgmt. Options
 - 2 problem points for established problem worsening (HTN)
 - 1 point for established stable problem (dyslipidemia) 2 + 1 = 3 points
- Data Points = 1 point for ordering labs

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Established Patient Office Visit

Determine Level of Risk

- Qualifies as Moderate Risk based upon either
 - Presenting problem of "chronic illness with mild exacerbation" because of worsening HTN
 - Prescription drug management –
 Amlodipine increased from 5 mg.
 to 10 mg.

Established Patient Office Visit

MDM - Table of Risk Guide

- Choose Highest Level in Any Box

Risk level	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Mgmt Options Selected
Min	Self limited or minor	Lab tests, CXR, EKG, echo	RICE, superficial
	e.g. cold, bug bite		dressings
Low	2 + minor problems	Pulm function tests	OTC drugs, minor
	1 stable chronic illness i.e. HTN	Non-cardio imaging, i.e. barium enema	Surgery, physical therapy
Mod	Chronic illness w/mild exac, 2 stable or 1 comp. illness/inj.	Dx endoscopies, Deep needle or incisional Bx, cardiac cath,	Elective maj. Surg Pres. Drug mgmt, Nuc, med
High	Chronic illness w/ severe exac, injury	Cardiovascular imaging studies w/ risk factors,	Ele. Maj. Surg w/risk, emer surgery
	or illness posing threat to life, abrupt neuro change (TIA)	Diagnostic endoscopies w/ risk factors, discography	Parenteral cont. substance, drug tx w/ monitoring

Established Patient Office Visit

Determine Level of MDM

MDM	Problem Points	Data Points	Risk
Straight- forward	1	1	Minimal
Low	2	2	Low
Moderate	3	3	Moderate
High	≥4	≥4	High

Established Patient Office Visit

Now Determine the Established Patient

Visit Level – Requires 2 Key Components

E/M Level	History	Exam	MDM
99211	Undefined	Undefined	Undefined
99212	PF	PF - 1997	Straight- forward
99213	EPF	EPF - 1995	Low
99214	Detailed	Detailed	Moderate
99215	Comp	Comp	High

Time Factors

- Usually visit level is determined by the extent of history and examination and the complexity of medical decision making
- Specific times expressed in CPT® for E/M levels are averages may be higher or lower depending on actual clinical circumstances

Visits Dominated by Counseling

- When counseling and/or coordination of care dominates an E/M, the level of service is determined by the amount of intra-service time spent with the patient.
 - Do not include time spent by nursing or other ancillary staff.
- Intra-service times are defined as:
 - Face-to-face time for office or other outpatient visits
 - Unit/floor time for hospital and other inpatient visits

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Selecting Visit Level by Time

- When more than 50% of the total visit time is spent counseling a patient with symptoms or an established illness, time should be used to determine the level of service. Common counseling topics include:
 - Diagnostic results
 - Recommended diagnostic studies
 - Recommended treatment options

Selecting Visit Level by Time

- Prognosis
- Risks and benefits of management/treatment options
- Instructions for management/treatment and/or follow-up
- Importance of compliance with chosen management or treatment options

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Documenting Time

- Total time (face-to-face in office or unit/floor time in hospital or inpatient setting)
- Time spent counseling and/or coordinating care (must be > 50% of total visit time)
- Content and topics discussed
- Any history, exam or medical decision making performed
- Select visit level by average time in CPT®

Example - Time

- Physician documented a problem focused history and exam with low complexity MDM. The patient is established and provider counseled patient on importance of medication compliance, diet and exercise to keep her HTN under good control
- This would normally be a 99212 by key components

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Example - Time

- The provider documented that 25 minutes of the 30 minute visit was spent counseling the patient.
- The provider documented the nature of the counseling and the topics discussed.
- The visit level would increase to a 99214 because counseling and/or coordination of care dominated the visit.
- Average time in CPT® for 99214 is 25 minutes.

Consultations

- CPT definition: Type of service provided by physician whose opinion is requested by another physician
- Requirements for consult the 3 "R"s
 - Request reason for the request must be documented in patient record.
 - Review consultant documents his or her opinion in the patient record, including any other services or test.
 - Report think as a verb consultant reports findings to requesting physician. Method of communication doesn't matter, but needs to be documented.

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Consultations

- Two sets of codes based on setting
 - 99241 to 99245 used for outpatient or office setting. This includes home visits, observation, ER pts not admitted, and rest home
 - 99251 to 99255 used for hospital inpatients or nursing facility residents.
 - Only one initial consultation per consultant can be used per admission
 - Subsequent visits by consultant use subsequent visit codes, i.e. 99231-99233 for hospital inpatients.

Resource/Reference List

- Current Procedural Terminology (CPT®) published by American Medical Association
- Evaluation & Management Services Guide http://www.cms.hhs.gov/MLNProducts/downloa ds/eval_mgmt_serv_guide.pdf
- CMS 1995 Guidelines http://www.cms.hhs.gov/MLNProducts/downloa ds/1995dg.pdf
- CMS 1997 Guidelines http://www.cms.hhs.gov/MLNProducts/Downlo ads/MASTER1.pdf

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Resource/Reference List

- http://www.medicarenhic.com/providers /articles/E_M_complete.pdf
- Check your local Medicare carrier/MAC website for their E/M guidelines and worksheets – they vary, so follow yours
- www.EMuniversity.com
 Sign up for e-mail case of the week and sharpen your skills

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November 19, 2009

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December 3 & 8, 2009

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Each person seeking CE credit must complete the sign-in form and evaluation in order to view and print their CE certificate

Certificates will be awarded for AHIMA Continuing Education Credit

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Resource/Reference List

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Evaluation & Management Services Guide

http://www.cms.hhs.gov/MLNProducts/downloads/eval_mgmt_serv_guide.pdf

CMS 1995 Guidelines

http://www.cms.hhs.gov/MLNProducts/downloads/1995dg.pdf

CMS 1997 Guidelines

http://www.cms.hhs.gov/MLNProducts/Downloads/MASTER1.pdf

NHIC Corp, Inc. E/M Coding Requirements (article and worksheet) http://www.medicarenhic.com/providers/articles/E_M_complete.pdf

E/M University

http://www.EMuniversity.com - Sign up for e-mail case of the week and sharpen your skills

Remember:

Check your local Medicare carrier/MAC website for their E/M guidelines and worksheets – they vary, so follow yours



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