

Foundations of Emergency Medicine**Foundations III: Guided Small Group Experience****Session 22: “Billing, Coding and Handoffs”****Unit: Clinical Skills****❖ Agenda and Learning Objectives**

- Case Part I – Basics of Billing and Coding (20 min)
 - Outline basics of billing from a chart
 - Define the evaluation and management (E/M) level coding system
 - Practice coding in small groups
- Case Part II – Patient Handoffs (20 min)
 - Discuss the importance of high-quality handoffs
 - Outline two standardized models for patient sign-out (IPASS and Safer Sign Out)
 - Practice sign-outs using the Safer Sign Out method
- Case Concludes (10 min)
 - Review Session Teaching Points

❖ Note to Facilitators

This first part of this session outlines the basics of billing and coding and gives residents practice coding a patient case. The second part of the session focuses on patient handoffs and introduces two standardized methods for improving patient handoffs. This part concludes with practice using the Safer Sign Out method. This is a large group quest led group discussion with imbedded small group practice. Before facilitating, please print off the small group assignments attached at the end of this facilitator guide (both practice coding as well as handoffs).

❖ Case Begins – Basics of Billing and Coding (20 min)

You have just graduated from residency and are working for a small democratic group. At your six-month meeting with your medical director, you are told that your patients really like you, you are seeing an appropriate number of patients but are regularly having charts “down-coded” and are therefore not eligible for your full “at risk” pay. You are obviously unhappy to hear this and want to work to improve your charting in the future to fully capture your charges.

❖ Discussion Questions with Teaching Points

- **What is the purpose of a medical record?**
 - To provide a record of what occurred and the related testing and diagnoses for the future care of the patient
 - To provide an explanation of the thought processes for legal issues related to care

- To provide a record for billing
- How do insurance companies decide how much to charge a patient for medical care?
 - In this country, Medicare is the largest payer for medical care → insurance companies like Blue Cross, Aetna and Cigna often set their reimbursement for care as a multiple of the Medicare reimbursement rate
 - Insurance companies often also follow Medicare expectations for documentation
 - Medicare reimburses the professional fee for emergency physicians on an Evaluation and Management (E/M) level coding system
- **What is the E/M coding system? What is a CPT code? What is a medical coder and what do they do?**
 - The E/M code is based on the medical complexity of the care that you provide → this is based on elements in the HPI, physical and medical decision-making portions of your chart
 - The number of each elements determines the E/M coding and the **lowest** scoring part of the chart determines the chart E/M level
 - A level 5 chart is the highest complexity outside of critical care
 - Medical coders dissect charts for elements in each of these areas and use tables to determine the E/M code (see below)
 - Once an E/M level is chosen, they are assigned a CPT code (current procedural terminology code) which corresponds to a dollar amount for Medicare
 - As stated above, insurance companies often tie payments to the CPT code dollar amount set by Medicare (as a multiple)
- **What are the specific requirements for each E/M level in the Emergency Department? For history? For physical? For medical decision making?**
 - There are two acceptable scoring systems due to changes in the rules between 1995 and 1997
 - The **history** portion requires four specific areas of documentation:
 - The **chief complaint** needs to be clearly stated → often in the patient's own words
 - The **HPI** elements include location, quality, duration, context, timing, modifying factors, associated signs and symptoms → needs to include 4 of the following elements for a level 5 chart
 - The **ROS** includes 14 possible systems that can be reviewed → you need > 9 systems for a level 5 (highest level) chart
 - There are three elements to the **past history** (PMFSHx) includes medical history (including surgical), social history and family history → you need 2/3 for a level 5 chart
 - The **physical exam** scoring system is complicated and different based on which guidelines you are using → generally speaking for a level 5 chart you need 8 systems

- A good rule is the **4-10-2-8** rule for a level 5 chart → you need 4 elements for the HPI, 10 ROS, 2 historical (PMFSHx) and 8 areas of the physical exam
- On the flip side, it's important to know what will be low complexity regardless (i.e. ankle sprain) and not over document to save you time and effort

E/M Level	History	Physical Exam	CPT Code
CPT Code 99281	PF 1-3 points	1 system; 1-5 bullets	Straightforward
CPT Code 99282	EPF 1-3 points, 1 ROS	2-4 systems; 6-11 Bullets	Low Complexity
CPT Code 99283	EPF 1-3 points, 1 ROS	2-4 systems; 6-11 Bullets	Moderate Complexity
CPT Code 99284	Detailed; 4 HPI; 2-9 ROS; 1/3 PMFSHx	5-7 systems; 12 bullets in 2 systems	Moderate Complexity
CPT Code 99285	Complete; 4 HPI; 2-9 ROS; 2/3 PMFSHx	8+ systems; 9+ systems w/ 2+ bullets	High Complexity

- **How is the medical decision-making section coded and billed? What are some examples of each level?**
 - MDM complexity is scored based on three areas → diagnosis and treatment, data that was interpreted and risk associated with the diagnoses and treatment plans
 - The diagnosis and treatment score is divided into 5 levels
 - Self-limited and minor
 - Established problem that is stable
 - Established problem that is worsening
 - New problem with no added workup
 - Diagnosis is a new problem and will generate additional work-up
 - The data portion includes whether you order testing, radiology studies, ECGs and whether you **independently** interpreted these (and documented that)
 - You also get additional credit for accessing and interpreting old data and notes
 - i.e. if you interpret your own ECG you must write down the rate, rhythm, axis, presence of ectopy and diagnosis (“sinus tachycardia at rate of 120 with no ectopy and no ST/T wave abnormalities. This tracing is adequate and interpreted by me. No previous ECGs available for comparison”) → if you compare to an old ECG you get additional complexity
 - The risk assigned is based on assessment in three categories → the problem, the diagnostics required to find it and the complexity of management
 - This is generally low, medium or high risk
- **What about critical care time? How is that billed? Are procedures bundled into critical care time? What is the percentage of critical care charts for an average EM physician?**

- Medicare allows us to bill using time (over 30 minutes) instead of elements for critically ill patients
 - The critical care codes are 99291 for the first 30-74 minutes and 99292 for each additional 30 minutes beyond 74
 - You may use critical care time if the patient has a condition that impairs one or more vital organ systems and there is a high probability of life-threatening deterioration in the patient's condition
 - You must spend 30 minutes or more exclusively on the care of that patient → this can include the following
 - Discussions with the family or patient
 - Documentation of test results
 - Bedside time (ie vent management, vasoactive drug titration)
 - Re-assessment
 - Discussions with consultants
 - This cannot be done by the resident or PA/NP
 - Some procedures are separately documented (ie central line, intubations) though some are bundled
 - In an average practice 2-4% of patient encounters are coded as critical care → however, remember that when you are training at an academic institution you often see a high proportion of critically ill patients so what you think of as lower acuity may actually be critical care (ie atrial fibrillation with RVR)
- **The next session will allow residents to practice coding on hypothetical cases. The cases (and key) are at the end of this facilitator guide.**

❖ **Case Part II – Patient Handoffs (20 min)**

You are taking sign out after a busy weekend overnight shift from a fellow resident. It is scattered and there are several questions you have to ask several times to get the correct information. Several of the plans are incomplete and you are left with an unclear path for those patients. The resident signing out seems frustrated and you become frustrated also. You end up having to retake a history for several of the patients when their plan changes unexpectedly and you wonder how this could have gone better.

❖ **Discussion Questions with Teaching Points**

- **Why are handoffs important? What data do we have that this is a high-risk time?**
 - It has been shown that up to 60% of the time the most important piece of information is not relayed during hand-offs
 - Hand-offs, both at shift change and at admission, have been shown multiple times to be a high-risk time for patient care
 - Up to 70% of malpractice suits involve some aspect of communication, often between physicians

- **Let's spend a few minutes discussing cases you have had that have gone poorly due to difficulties with the handoff process. What did you learn from those experiences? What are some best practices you have seen for effective handoffs? What are some things you have noticed do not work well?**

- **What standardized methods have been developed for handoffs? Why might this be useful?**
 - Organizations requiring high reliability (ie the military, airline industry, nuclear power) have developed ways to ensure that communication organized and standardized
 - Many advocate a similar process in medicine to reduce communication errors during patient handoffs → a study at one hospital showed a decrease of 50% in adverse events after the implementation of a standardized sign-out process
 - Two common methods described are the IPASS and Safer Signout methods both based on SBAR (situation, background, assessment, recommendations) designed by a former submarine officer working for Kaiser
 - IPASS is a mnemonic standing for:
 - I: Illness severity (stable, watcher, unstable)
 - P: Patient summary statement
 - A: Action list
 - S: Situational awareness and contingency planning
 - S: Synthesis by receiver → receiver summarizes information and restates key points
 - IPASS is a longer process and less applicable to the ED environment so the Safer Signout process was developed for ED use by the Emergency Medicine Patient Safety Foundation
 - The Safer Sign Out model has 5 key components:
 - Record the patient information, vital signs, critical details and follow-up items on a paper form
 - Review this form with the oncoming clinician in front of the computer so chart information is available
 - Round in the patient's rooms with the oncoming clinician to meet the patient and ensure communication of the plan
 - Relate the plan to the other team members by discussing it with the nurse before, during or after patient rounding
 - Receive feedback on the sign-out forms as they are collected and reviewed

- The Emergency Medicine Patient Safety Foundation has the following recommendations for best practices as relating to handoffs
 - The off-going clinician should pre-round with the patients prior to starting sign out so that he/she can prepare the patient for the ongoing clinician. This activity allows the

review of vital signs and exam findings and can reinforce the treatment plan. This activity may increase the overall efficiency of the process and save their colleague time later on.

- After the on-going clinician has been briefed on the patients and summarizes the plans to the off-going clinician, the off-going clinician should confirm that there is a mutual understanding the sign out with the question: “What questions do you have?”
- Every effort should be made to minimize interruptions during sign out. This can be having sign out in a protected area, and indicating to the nurses that you are in sign out
- All forms should be collected and put in a common place. These forms can be used for the QA process to try and improve sign out and patient care
 - **Let’s spend the last few minutes of this session practicing the Safer Sign Out process. Follow the steps below to complete the small group activity.**
 1. Have every group label their Safer Sign Out Form
 2. Give every group of residents three sample cases with patient’s information
 3. Give each group 5 minutes to use the information on the cards to fill out a safer sign out form
 4. Have one group sign out to a second group, modeling the behavior of first pre-rounding, communicating with the nurse (instructor can be the nurse) and then signing out to the oncoming clinician

❖ Case Teaching Points Summary

- Billing and Coding
 - The medical record provides information on what happened to the patient, a description of your thought processes, and the information needed to generate a bill
 - Most emergency department medical records are coded on the basis of 5 different evaluation and management levels: 99281 through 99285
 - Cases that are critical in nature can be coded with critical care CPT codes, which rather than requiring a certain number of bullets in each chart section, can be coded as requiring a specified amount of time where you were devoted entirely to the care of a single patient. This usually generates a larger physician professional fee than the most complex evaluation and management code, but requires that you spend at least 30 minutes involved in the care of a single patient.
 - The most effective way to learn to document is through practice and feedback from your coders directly to you. Common problems are too few items in the review of systems or inadequate histories or an inadequate number of items on physical exam.
 - Ensure that you have a well-written medical decision-making paragraph summarizing your concerns about the risks to the patient, what you thought was going on, how you interpreted your tests, and what you overall plan on doing.
- Handoffs
 - Transitions of care such as shift change handoffs are one of the most common procedures that we perform
 - Using a structured method of sign-out reduces the risk to our patient, conveys the information necessary to continue their treatment, and provides better care

- Developing a standardized method for care transitions means incorporating nursing staff into the process and leadership support throughout the department
- Using a method such as IPASS or Safer Sign Out requires practice and deliberate attention but will leave you feeling better about the care that you provide

❖ Facilitator Background Information

Having a basic understanding of billing and coding is important for any emergency physician and more so, for those of us who are expected to do our own billing and coding. With practice, including the correct number of components for various levels of charges becomes second nature but it's important for residents to begin practicing (or at least thinking about billing) prior to graduation. This session covers the basics of billing and coding as well as gives residents some practice on coding various types of encounters including an introduction to critical care billing.

Handoffs are becoming a focus of QI efforts throughout medicine as they are a common cause of medical error both within the ED as we handoff between providers but also between the ED and admitting or consulting teams. There have been several standardized protocols proposed to improve the safety of signouts based on data from other industries requiring high fidelity transfer of information such as aviation and the military. These include the IPASS system and the Safer Signout system both of which have showed improved outcomes for data transfer. This session will allow residents to practice the Safer Signout system.

❖ References

- **Author:** Dr. Dean Johnson
- **Editors:** Dr. Natasha Wheaton
- **References:**
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 - The Business of Emergency Medicine: From Care to Compensation on the AAEM Resident and Student Association Website:
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- ED Charting and Coding: Critical Care Time
[\(https://www.aliem.com/2017/07/charting-coding-critical-care-time/\)](https://www.aliem.com/2017/07/charting-coding-critical-care-time/)

Billing and Coding Sample Practice Cases (For Residents)

1) A patient who comes to the emergency department for a medication refill because they are from out of town. They have normal vital signs, and they are asking for seven days of lisinopril 10 mg.

2) A 17-year-old male who twisted his ankle when he was playing basketball, is able to walk and using the Ottawa ankle rules does not have evidence of bony injury. He has a good pulse in his foot, is minimally swollen anterior to the lateral malleolus, has FROM of his foot. There's no knee injury and he otherwise feels well.

3) A four-year-old asthmatic comes in wheezing, has had fever (100.6) for the last several days, has a saturation of 92% and improves after one nebulizer treatment. This patient has mild hypoxia, tachycardia and tachypnea, bilateral wheezing and mild retractions. After exam, she is given a nebulizer albuterol treatment, reexamined and feels much better. Her tachycardia resolves, she is given steroids and she is no longer hypoxic, wheezing or retracting. She is discharged home on prednisone and albuterol MDI and spacer with a follow-up within 24 hours.

4) A 27-year-old female comes in with right lower quadrant pain whose last period was seven weeks ago. She's had some spotting, no vaginal discharge, otherwise feels well. She gives a history of this RLQ pain starting over the last several days, coming and going in a cramp-like manner, being moderate in severity and associated with being lightheaded and sweaty when it is most intense. On her ROS she denies chest or respiratory problems, no ENT or eye problems, some low back pain associated with the cramping, some mild dysuria, a rash down near her vaginal area and some minimal leg swelling. No other parts of her ROS are positive. Social history is remarkable for her smoking. On exam she has slight tachycardia with a heart rate of 110, is normotensive, and has some mild right lower quadrant tenderness. She has several small blister-like lesions on her labia.

5) You see a sweaty 65-year-old male who is complaining of chest pain. He is obviously in distress, diaphoretic, initially hypotensive, having multiple PVCs on the monitor and looks quite ill. You review his EKG, which demonstrates an inferior wall myocardial infarction, so you briefly review his past medical history that includes three stents following a CABG, smoking, hyperlipidemia and hypertension. You make note of his diabetes, order labs and aspirin, call cardiology and send him to the Cath Lab. His ROS was negative except for dyspnea on exertion worsening in the last three day. You noted on his physical exam his tachypnea, diaphoresis, diminished pulses in extremities, and hypotension. The remainder of his complete exam was normal. While he's in the Cath Lab his troponin returns positive, he's noted to be anemic, and his chest x-ray is read as mild fluid overload. When you looked at his chest x-ray and compared it to a previous one this one looks worse. Your final diagnosis is myocardial infarction.

Safer Sign Out Sample Cases

1) Mr. J is a 57-year-old male, with a history of diverticulitis who presents with left lower quadrant pain that has been going on for three days. Vital signs are P 102, RR 24, O2 Sat 93%, T 38.4 C.

Labs are remarkable for a chemistry with a sodium of 129, chloride of 99, potassium of 2.6 and bicarbonate of 16. CBC had an alleyway flip count at 16.7, is not anemic.

CT scan of the abdomen with IV contrast is currently pending.

Depending on results of the CT, the patient needs to be either discussed with surgery or medicine. He should not be discharged.

2) Mrs. F is a 27-year-old female who presents with left lower quadrant pain that started suddenly. She is sexually active in a monogamous relationship. Last menstrual period was six weeks ago. Most recent vital signs are P 98, BP 102/74, RR 20, O2 Sat 98%, T 37.4 C.

Labs are remarkable for hemoglobin of 7.4. Urine pregnancy test is currently pending.

If urine pregnancy test is negative, I would consider a serum pregnancy test before discounting the possibility of an ectopic pregnancy.

3) Mr. Q is a 22-year-old male who twisted his ankle while playing basketball two hours ago. He just arrived, vital signs are normal, x-rays are pending since he was not able to walk.

4) Ms. N is a 7-year-old female with a both-bone mid-forearm fracture who will require procedural sedation. Vitals remarkable for a P 116 initially, 88 now. Remaining vitals are BP 90/54, RR 18, O2 Sat 98%, T 37.2 C. Normal heart and lung exam, nothing to eat for the last 5 hours and no recent respiratory infections.

Currently awaiting orthopedics and the plan is procedural sedation when the orthopedic surgeon comes out of the OR. Most recent medication was 1 mg morphine sulfate given 30 minutes ago, no resulting nausea and she otherwise feels much better. Disposition as per orthopedic surgery.

5) Mr. D is a 16-year-old male with history of asthma with an exacerbation after being exposed to cats and who has received dexamethasone, and two albuterol/ipratropium treatments. Vitals are P 98, RR 24, O2 Sat 90%, T 37.4 C. He seems to be improving.

Plan is one more hour of observation, another albuterol treatment, and reassesses oxygenation. If he is improved to 95% or better saturation he can go home. I have already discussed the case with his pediatrician.

6) Mr. F is a 31-year-old male seen by the trauma team, status post motor vehicle crash. I assisted with the airway, and he is currently on the ventilator. Most recent vitals were P 130, RR is 18 AC mode, TV

450, PEEP 5, FiO₂ 40%, O₂ Sat 98%, T 37.3 C. Rocuronium was given 20 minutes ago. Received 100 µg fentanyl IV and is currently sedated on a midazolam drip. Labs pending.

Nothing to do on this case, disposition per trauma.

7) Ms. Y is a 75-year-old female with COPD on BiPAP, currently receiving her second breathing treatment. Initial vitals P141 Irreg, R 48, T 39.2 C. Unable to talk when I first saw her, severe respiratory distress, initial saturation of 82%, poor air movement but didn't want to be intubated. In atrial fibrillation with RVR and just given first dose of 0.25 mg/kg IV diltiazem. Placed on BiPAP and receiving albuterol/ipratropium treatments. She has also received IV methylprednisolone. Chest x-ray is currently pending. Initial labs are unremarkable except for a positive troponin of .14.

She is improving on BiPAP, with RR down to 36 and O₂ Sat 92%. Please check the chest x-ray to insure that there is no pneumothorax or infiltrate, and decide whether or not she needs to go to the ICU or step down unit.

8) Young Mr. B is 4-year-old boy with 2 days of severe, non-bloody diarrhea, initially tachycardic with delayed capillary refill of 4 seconds. P 136, RR 24, BP 94/60, O₂ Sat 94%, T 37.2 C. Some mild abdominal tenderness without rebound, no peritonitis. Lungs clear, skin as above, heart tachycardic but normal His older sister just recovered from a similar illness. Currently receiving his first normal saline bolus.

Please recheck after the fluid bolus. His pediatrician is Dr. Eyeluvkids who can see him tomorrow in follow-up but would like to know whether you feel he requires admission.

9) Ms. N is a 47-year-old female with epigastric pain, worse after meals. Vitals P 104, R 18, BP 154/86T 38.4 C, 94% O₂ Sat.

Alkaline phosphatase 507, Total Bilirubin 2.1; WBC 19.4k

Physical exam remarkable for epigastric tenderness. Ultrasound of the right upper quadrant pending. Disposition after RUQ ultrasound.

10) Mr. C is a 67-year-old male on warfarin fell against his bathtub this evening. He may have been knocked out. He has a 5 cm occipital laceration that I have repaired. He currently is waiting for his CT scan of his head and neck. P 98, RR 16, BP 168/92 O₂ Sat 93%, T 36.8 C. Physical exam was remarkable for lower cervical tenderness and the occipital laceration.

Labs are remarkable for an INR of 3.7, platelet count of 250 K, and a hemoglobin of 11.4.

I expect that he will be able to go home after the complete evaluation. He lives with his wife and adult children 5 minutes from the hospital.

11) Mrs. B is a 62-year-old female, postoperative day 9 from a right total knee replacement. She is here with swelling of her right leg. P 67, RR 15, BP 148/72, O₂ Sat 97%. On exam her right leg is somewhat swollen, she has good distal pulses, her surgical wound looks well-closed without drainage or surrounding erythema.

Labs are remarkable for a white count of 9.6 K, platelet count 250K, normal chemistries. X-ray of right knee is unremarkable.

Ultrasound for DVT is pending. Dr. Osgood Schlatter would like a phone call after the ultrasound is done.

12) Ms. D is a 5-year-old girl with sickle cell disease. She presented today with her typical joint pain in her knees and elbows but also a recent respiratory infection. This is her 2nd sickle cell crisis this year. Vital signs are P 110, RR 28, BP 86/58 O2 Sat 88%, T 37.6. No abdominal tenderness, normal neuro exam, systolic flow murmur, rhonchi in left lung base and mildly swollen knees bilaterally.

Labs are remarkable for a Hemoglobin of 8.5 which is her baseline. Her reticulocyte count is pending. Chest x-ray is pending. She has received 2 rounds of morphine for pain control, and says her pain is down to a 5. She normally feels better after 2 rounds. Her hematologist is Dr. Wallace Coulter, who would like an update. Plan for admission here but may have to transfer if she is aplastic.

Safer Sign Out Form (v20)

Check if No Patients Signed Out Off-Going Clinician*: _____ Receiving Clinician: _____ Date Shift Started _____

Patient Name/Age	Problem List & Key Issues	Pending Items	Disposition	Receiving Clinician's Notes
<div style="border: 1px solid black; padding: 2px; margin-bottom: 5px;">Room</div>	Diagnostic/CC: _____ Key Issues: _____ _____ Potential Safety Issues or Precautions? _____		Home _____ Admit _____ Transfer _____ NH _____ TBD _____	<input type="checkbox"/> Rounded on Patient <input type="checkbox"/> Communicated with Nurse _____
<div style="border: 1px solid black; padding: 2px; margin-bottom: 5px;">Room</div>	Diagnostic/CC: _____ Key Issues: _____ _____ Potential Safety Issues or Precautions? _____		Home _____ Admit _____ Transfer _____ NH _____ TBD _____	<input type="checkbox"/> Rounded on Patient <input type="checkbox"/> Communicated with Nurse _____
<div style="border: 1px solid black; padding: 2px; margin-bottom: 5px;">Room</div>	Diagnostic/CC: _____ Key Issues: _____ _____ Potential Safety Issues or Precautions? _____		Home _____ Admit _____ Transfer _____ NH _____ TBD _____	<input type="checkbox"/> Rounded on Patient <input type="checkbox"/> Communicated with Nurse _____



This form is a Quality Assurance Tool and is **NOT** part of the medical record

Billing and Coding Sample Practice Cases Key (For Facilitators)

1) A patient who comes to the emergency department for a medication refill because they are from out of town. They have normal vital signs, and they are asking for seven days of lisinopril 10 mg. Simple problem, single exam (BP and general appearance) and low complexity and straightforward diagnosis.

2) A 17-year-old male who twisted his ankle when he was playing basketball, is able to walk and using the Ottawa ankle rules does not have evidence of bony injury. He has a good pulse in his foot, is minimally swollen anterior to the lateral malleolus, has FROM of his foot. There's no knee injury and he otherwise feels well. His history and physical exam findings are limited in scope. This would be an example of an expanded problem focused chart.

3) A four-year-old asthmatic comes in wheezing, has had fever (100.6) for the last several days, has a saturation of 92% and improves after one nebulizer treatment. This patient has mild hypoxia, tachycardia and tachypnea, bilateral wheezing and mild retractions. After exam, she is given a nebulizer albuterol treatment, reexamined and feels much better. Her tachycardia resolves, she is given steroids and she is no longer hypoxic, wheezing or retracting. She is discharged home on prednisone and albuterol MDI and spacer with a follow-up within 24 hours. The history of the patient involves several items including the onset, duration, severity and associated symptoms. Several exam findings: tachycardia, wheezing, retractions, general appearance, moderate complexity and treatment, and moderate risk. This is a level 99283 chart.

4) A 27-year-old female comes in with right lower quadrant pain whose last period was seven weeks ago. She's had some spotting, no vaginal discharge, otherwise feels well. She gives a history of this RLQ pain starting over the last several days, coming and going in a cramp-like manner, being moderate in severity and associated with being lightheaded and sweaty when it is most intense. On her ROS she denies chest or respiratory problems, no ENT or eye problems, some low back pain associated with the cramping, some mild dysuria, a rash down near her vaginal area and some minimal leg swelling. No other parts of her ROS are positive. Social history is remarkable for her smoking. On exam she has slight tachycardia with a heart rate of 110, is normotensive, and has some mild right lower quadrant tenderness. She has several small blister-like lesions on her labia. Differential diagnosis includes appendicitis and ruptured ectopic (both moderate to high risk). You check her pregnancy test (positive), CBC, type and cross her and check her ultrasound - finding her ruptured ectopic. This can be either a level 4 or, more likely, level 5 (99284 or 99285) chart.

5) You see a sweaty 65-year-old male who is complaining of chest pain. He is obviously in distress, diaphoretic, initially hypotensive, having multiple PVCs on the monitor and looks quite ill. You review his EKG, which demonstrates an inferior wall myocardial infarction, so you briefly review his past medical history that includes three stents following a CABG, smoking, hyperlipidemia and hypertension. You make note of his diabetes, order labs and aspirin, call cardiology and send him to the Cath Lab. His ROS was negative except for dyspnea on exertion worsening in the last three day. You noted on his physical exam his tachypnea, diaphoresis, diminished pulses in extremities, and hypotension. The remainder of his complete exam was normal. While he's in the Cath Lab his troponin returns positive, he's noted to be anemic, and his chest x-ray is read as mild fluid overload. When you looked at his chest x-ray and compared it to a previous one this one looks worse. Your final diagnosis is myocardial infarction. His chart should generate 99285 - extensive HPI, ROS was complete, Two of 3 PMFSHx values, complete physical and high complexity design making with a high-risk diagnosis.