Money talks: Quality, Safety, and Billing in Acute Care

Documentation Guidelines

Leslie Kaelin CCP, CCP-AS, CPC
Clinical Documentation Specialist

Disclosure

I have no financial disclosure or conflicts of interest with the presented material in this presentation.

Documentation Guidelines Overview

- E/M codes are levels of services that include a medically appropriate history and/or physical examination, when performed. The nature and extent of the history and/or physical examination are determined by the treating physician or other qualified health care professional reporting the service.
- The level of the Medical Decision Making as defined for each service, or
- The total time for E/M services performed on the date of the encounter.

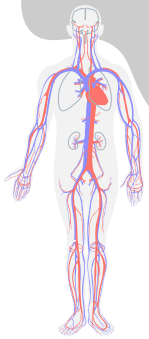
New or Established Patients
New – no services within the last 3 years.
Established – have received services within the last 3 years.

E & M Codes

E&M	History & Exam	MDM
99282	Medically Appropriate History and/or Exam	Straightforward
99283	Medically Appropriate History and/or Exam	Low
99284	Medically Appropriate History and/or Exam	Moderate
99285	Medically Appropriate History and/or Exam	High

2023 Medical Decision Making

- MDM is defined by three elements.
- The number and complexity of problem(s) that are addressed (COPA) during the encounter.
- The amount and/or complexity of data to be reviewed and analyzed.
- The risk of complications, morbidity, and/or mortality of patient management decisions made at the visit, associated with the patient's problem(s), the diagnostic procedure(s), treatment(s).



Medical Decision Making Elements

COPA

Complexity of Problems Addressed:
- Minimal
- Low
- Moderate
- High

DATA

Data:
- Minimal or None
- Limited
- Moderate
- Extended

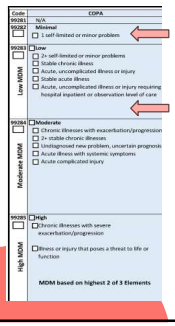
RISK

Risk:
- Minimal or None
- Low
- Moderate
- High

The level of services is based on two of the three components meeting or exceeding the level of service.

COPA

Complexity of Problems Addressed



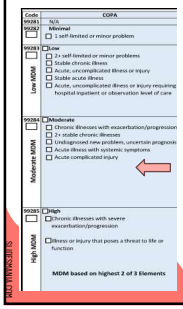
- **Minimal**
  1 Self-limited or minor problem
- **Low**
  * 2 self-Limited or minor problems
  * Stable chronic illness
  * Stable acute illness
  * Acute uncomplicated Illness/Injury: *There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected.*

  From a Coder perspective..

  No lab test – No Imaging – No Prescription Meds

COPA

Complexity of Problems Addressed



Moderate
* Chronic Illnesses with exacerbation/progression
* 2+ Stable chronic illnesses*
* Undiagnosed New Problem with uncertain prognosis
* Acute Illness with systemic symptoms
* Acute Complicated injury

"A stable chronic problem is one that is addressed or managed when it is evaluated or treated at the encounter…"

Undiagnosed new problem with uncertain prognosis

Question: A patient complains of a sore throat, low-grade fever, and no other systemic symptoms. The strep test is positive, and medication is prescribed with a final diagnosis of strep throat. Would all urgent care complaints with prescription-drug management be considered undiagnosed new problems with uncertain prognosis? Can any problem presenting to an urgent care setting be counted as an undiagnosed new problem with uncertain prognosis?

CPT Assistant – September 2023

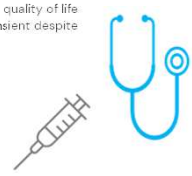
Undiagnosed new problem with uncertain prognosis

Answer: No, any new complaint may be a new problem but not to the level of "with uncertain prognosis." The need for an antibiotic alone would not create a high risk of morbidity, and minimal data needed to make the appropriate medical decision suggests the presenting problem is not being treated as a higher risk condition. This could be an acute uncomplicated illness and apparent as such at the outset.

Undiagnosed new problem with uncertain prognosis

A problem in the differential diagnosis that represents a condition likely to result in a high risk of morbidity without treatment.

Morbidity: A state of illness or functional impairment that is expected to be of substantial duration during which function is limited, quality of life is impaired, or there is organ damage that may not be transient despite treatment.



Acute illness with systemic symptoms

An illness that causes systemic symptoms and has a high risk of morbidity without treatment.

• For systemic general symptoms, such as fever, body aches, or fatigue in a minor illness that may be treated to alleviate Symptoms would be considered an acute, uncomplicated illness or injury

Acute Complicated Injury

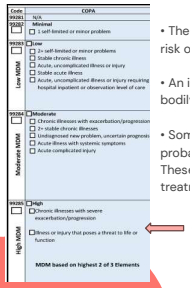
• Injuries that require evaluation of organ systems or body areas beyond the site of the injury (e.g., musculoskeletal injuries where an assessment of distal neurovascular function is indicated).

• Accidents and/or injuries that require diagnostic imaging to rule out fractures, dislocations, or foreign bodies are indicative of a potentially extensive injury with multiple treatment options and risk of morbidity.

COPA – From the coder perspective…
Moderate COPA

• Basic labs
• Plain film X-rays
• IV Fluids
• IV/IM Medications
• Rx pain management
• Rx antibiotics
• Isolated advanced study
–i.e., CT scan or EKG (not both)

High COPA



• The severe exacerbation of a chronic illness that has a significant risk of morbidity and may require escalation in level of care.

• An illness or complicated injury that poses a threat to life or bodily function in the near term without treatment.

• Some symptoms may represent a condition that is significantly probable and poses a potential threat to life or bodily function. These may be included in this category when the evaluation and treatment is consistent with this degree of potential severity.

COPA – High

• It is not necessary that a life-threatening condition is listed in the final diagnosis.

• An extensive evaluation to identify or rule out any condition that represents severe exacerbation or potential threat to life or bodily function is an indication of High COPA.

COPA – High

• Question: A patient presents with calf pain and the physician orders a STAT ultrasound to rule out deep vein thrombosis (DVT). Following the review of the test results, the physician later documents that the patient is stable enough that there is no concern for pulmonary embolism…

• Answer: The risk and complexity does not change with the outcome of a diagnostic test. The level of risk would be based on the physician's initial assessment of the patient during the visit. Based on that assessment, which described a potential high risk of morbidity or mortality requiring the STAT ultrasound to evaluate for potential DVT…

CPT® Assistant November 2022

COPA – High

• The final diagnosis for a condition does not, in and of itself, determine the complexity or risk, as extensive evaluation may be required to reach the conclusion that the signs or symptoms do not represent a highly morbid condition.

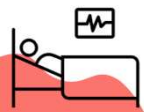
• Therefore, presenting symptoms that are likely to represent a highly morbid condition may "drive" MDM even when the ultimate diagnosis is not highly morbid.

• The evaluation and/or treatment should be consistent with the likely nature of the condition.

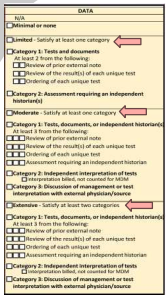
– CPT 2023

High COPA – From the coder perspective…

• Differential diagnosis
• Multiple or repeat labs
• Multiple or repeat x-rays
• Complex Imaging, i.e., CT, MRI, EKG, US
• Consult w/specialist
• Extended observation
• Multiple re-evaluations
• Admit / Transfer



DATA



Category 1
- Unique tests ordered
- Unique tests reviewed
- Review of prior external notes
- Assessment requiring an independent historian

Category 2
- Independent interpretation of tests

Category 3
- Discussion of management or test interpretation with external physician or other qualified health care professional or appropriate source.

DATA

Category 1
- Review of Prior External Notes from each unique source.

Any notes or documents that originate from an outside department.
- Inpatient charts
- Nursing home records
- EMS reports
- Charts from another facility or group
- KASPER report

DATA

Review and Summarization of Old Records

This is a perfect example of review and summarization of old records.

Imaging reviewed -imaging from outside hospital was obtained and reviewed which revealed mass behind the left orbit concerning for malignancy versus benign tumor

DATA

Category 1
- Review results of each unique test
- Ordering of each unique test

Ordering a test is included in reviewing the results

- Each unique test gets a checkmark.
  - CBC, CMP, BNP
- A unique test is a test for which there is a CPT code, and an interpretation or report is customary.

DATA

Ordering a test may include those considered, but not selected.

- These considerations must be documented.
- Rationale: Very low risk for intracranial injury (no LOC, normal GCS, no non-frontal scalp hematoma, acting normal to parent) will defer head CT with parent's agreement as unnecessary radiation.

DATA

Assessment requiring an independent historian.

Any individual who provides a history in addition to a history provided by the patient.
- EMS
- Parent
- Guardian
- Surrogate
- Spouse
- Witness

Due to:
- Developmental stage
- Dementia
- Psychosis
- Etc…

An interpreter is not an independent historian.

DATA

Assessment requiring an independent historian

History of Present Illness
Pt is a 4-year-old with no significant past medical history presenting to the ED with right ear pain. Mom says that he woke up from sleep at 2330 complaining of right ear pain. He was given ibuprofen at home prior to arrival. No fevers. He has had a chronic cough for several months. No abdominal pain. He sometimes coughs up sputum, but this is chronic and not new. No vomiting. He takes allergy medication. NKDA. Immunizations up-to-date. No history of hospitalizations. He had negative swabs done a few days ago at an outside facility.

DATA

CATEGORY 2: INDEPENDENT INTERPRETATION OF A TEST (NOT SEPARATELY REPORTED)

- Any service for which the professional component is separately reported by the physician or other qualified health care professional reporting the E/M services is not counted as a data element ordered, reviewed, analyzed, or independently interpreted for the purposes of determining the level of MDM.

DATA

Independent Interpretation of Test

This is an excellent example of an independent interpretation of test.

Electrocardiogram: Time 4/7/2024 11:25:00, rate 106, No ST changes, no ectopy, normal PR & QRS intervals, EP Interp, Sinus tachycardia without acute ischemic changes.

DATA

Category 3 – Discussion of management or test interpretation with external physician or another appropriate source.

Any external staff discussion
- Consultant
- PCP
- Surgeon
- Admitting Physician
- Radiologist

May also be organization:
- Hospital
- Nursing Facility
- Home health care agency

Appropriate source -
- Lawyer
- Parole officer
- Case manager
- Teacher
- Social Worker

Does not include intermediaries (clinical staff or trainees) or other members of your group.

DATA

Category 3 – Discussion of management or test interpretations with external physician or another appropriate source.

- Discussed with Dr. Jacobs from cardiology. She recommended cardioversion in the ED and contact her office for an appointment.
- Discussed with cardiology.
- Discussed with Dr. Jacobs.

DATA

Discussion of Management of Care

Question: When is the conversation between a physician and the admitting physician counted as an element in medical decision making (MDM) from the perspective of the physician?

CPT Assistant – August 2023

DATA

Answer: Determination of whether a conversation between physicians maybe applied toward MDM by the physician depends on whether the conversation is used in the MDM of the encounter.

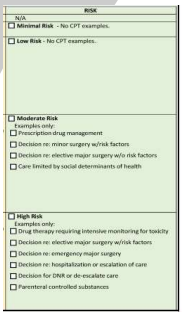
If the conversation is required to determine the next steps in how the patient will be treated (eg, admission, outpatient visit, additional testing/imaging), the physician may count the conversation as a data element for MDM when determining final E/M code selection for the encounter.

Alternatively, if the conversation between physicians was solely administrative (eg, notification of consult request) and was not used in the MDM of the physician when determining next steps in the patient's care, the discussion may not be considered when determining the appropriate MDM level.

Risk of Complications

- Trained clinicians apply common language usage meanings to terms such as high, medium, low, or minimal risk and do not require quantification for these definitions.
- Definitions of risk are based upon the usual behavior and thought processes of a physician/QHP in the same specialty.
- Per AMA/CPT "impossible to list all the possible patient management decisions in the MDM grid.

Risk



Low Risk
- No published definitions for Minimal or Low Risk.

Moderate Risk
- Prescription drug management
- Decision for surgery w/ risk factors
- Decision for elective minor surgery w/o risk factors
- Care limited by social determinates of health

High Risk
- Drug Therapy Requiring Intensive Monitoring For Toxicity
- Decision for elective major surgery w/ risk factors
- Decision for emergency major surgery
- Decision regarding hospitalization or escalation of care
- Decision for DNR or de-escalation of care
- Parenteral Controlled Substances

Risk of Complications and/or Morbidity or Mortality of Patient Management

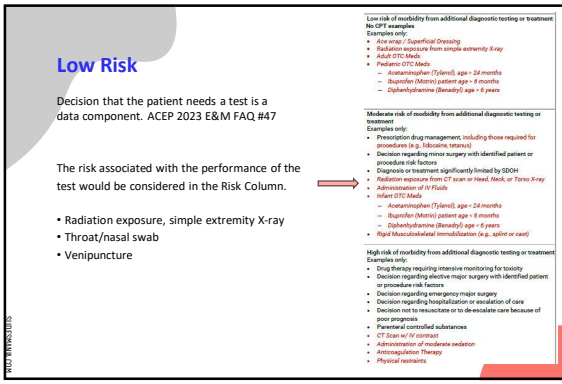
- The ACEP Coding and Nomenclature Advisory Committee (CNAC) consists of 30+ ED physicians who have expertise in medical coding and billing.

Low Risk

Decision that the patient needs a test is a data component. ACEP 2023 E&M FAQ #47

The risk associated with the performance of the test would be considered in the Risk Column.

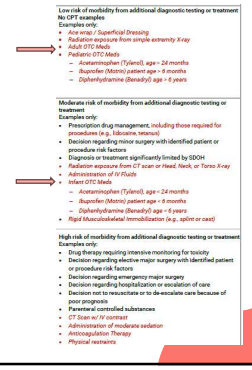
- Radiation exposure, simple extremity X-ray
- Throat/nasal swab
- Venipuncture



Low Risk

- Adult OTC Meds
- Pediatric OTC Meds
  - Acetaminophen (Tylenol), age > 24 months
  - Ibuprofen (Motrin) patient age > 6 months
  - Diphenhydramine (Benadryl) age > 6 years

- Some OTC medications require MD direction based on age/weight and/or comorbidities.
- Manufactures package insert recommends consulting a physician for infants.



Moderate Risk

Prescription drug management

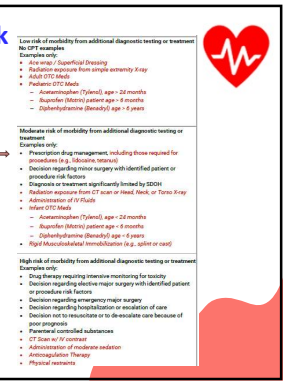
E/M FAQ -- Q. What constitutes "prescription drug management?"

"Prescription drug management" is based on documented evidence that the provider has evaluated the patient's medications as part of a service. This may be a prescription being written or discontinued, or a decision to maintain a current medication/dosage.

Note: Simply listing current medications is not considered "prescription drug management.

Does prescription drug management include medications that are given as treatment for the patient's condition, while the patient is in the Department?

Yes. Element 3, Risk, Moderate Risk, Examples includes prescription drug management. - AMA 2023 CPT Annual Symposium



Prescription drug management

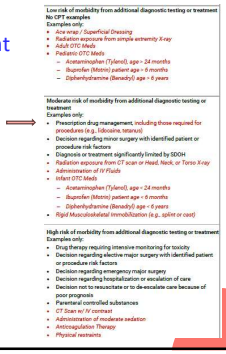
Management of drugs that do not require the intensive level of monitoring previously described can be included under the moderate-risk category.

- CPT® Assistant April 2022 / Volume 32 Issue 4

Does prescription drug management include medications that are given as treatment for the patient's condition, while the patient is in the Department?

Yes. Element 3, Risk, Moderate Risk, Examples includes prescription drug management.

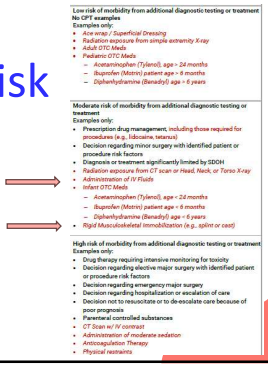
- AMA 2023 CPT Annual Symposium



Moderate Risk

Administering IV fluids
- Infection
- Fluid overload
- Allergic reaction

Rigid Musculoskeletal Immobilization
- Compartment Syndrome
- Pressure Ulcers
- Muscle Atrophy
- Deep Vein Thrombosis
- Thermal Injury

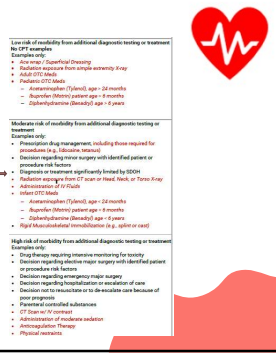


Moderate Risk

Diagnosis or treatment significantly limited by social determinants of health (SDOH) refer to the conditions of a patient's living environments or circumstances that affect their health risks and outcomes.

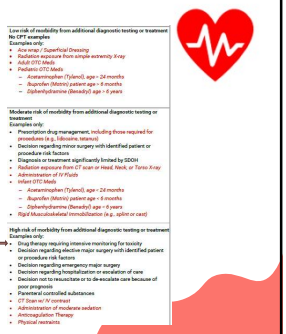
Documentation should how any SDOH have "significantly limited" patients' diagnosis or treatment.

- Living conditions
- Home environments
- Poverty
- Access to Healthcare



Drug Therapy Requiring Intensive Monitoring

- A drug that requires intensive monitoring is a therapeutic agent that has the potential to cause serious morbidity or death.
- The monitoring is performed for assessment of adverse effects and not primarily for assessment of therapeutic efficacy.
- The monitoring may be performed with a laboratory test, physiologic test, or imaging.
- Monitoring by history or examination alone does not qualify.



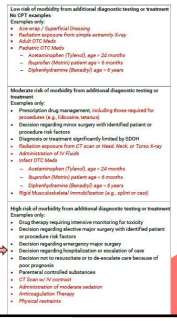
Drug therapy w/monitoring – ED relevant meds

Not an all inclusive list

Adenosine	Dobutamine	Isoproterenol	Potassium IV
Amiodarone IV	Dopamine	Labetalol IV	Precedex
Amrinone	Droperidol	Lidocaine IV	Procainamide
Atropine	Enalapril IV	Magnesium IV	Propofol
Bicarb IV	Ephedrine	Metoprolol IV	Sodium
Blood Products	Epinephrine IV, IM, SQ	Milrinone	Nitroprusside
Coumadin	Esmolol	Nicardipine IV	Thrombolytics
D50/Glucagon	Etomidate	Nitroglycerin IV	Vasopressin
Dexmedetomidine	Haldol IV	Nitroprusside	Verapamil IV

Decision regarding hospitalization or escalation of care

- "Decision Regarding Hospitalization" NOT "Decision to Hospitalize the Patient".
- Can be high risk if result is something other than the patient being hospitalized.
- Is hospital admission an appropriate outcome based on the patient's presentation and diagnosis?
- Does chart reflect the decision-making process around hospitalization?
  — Benefits of admission vs. risk of discharge
  — Provider recommends admission, patient declines.



Decision regarding hospitalization or escalation of care

Consideration of Admission:

During my evaluation and work-up I have determined that patient will be: discharged

Patient was still experiencing moderate to severe pain and I am concerned about her mildly elevated WBC. Discuss with patient and family the benefits of admission versus the risk of discharge, family is comfortable monitoring the patient at home. Will return to the emergency department If symptoms do not resolve or appear to be getting worse.

MD MMS2018

Parenteral – administered by means other than through the alimentary tract (intramuscular or intravenous injection)

Controlled Substance – usually schedule II or III drug.

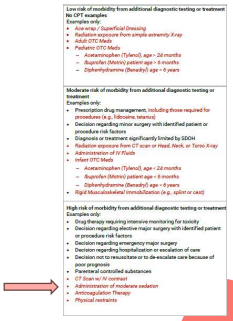
This list is not all-inclusive, but ED-relevant parenteral controlled substances may include:

- Buprenorphine (Suboxone)
- Clonazepam (Klonopin)
- Diazepam (Valium)
- Fentanyl (Sublimaze, Duragesic)
- Hydromorphone (Dilaudid)
- Ketamine
- Lorazepam (Ativan)
- Meperidine (Demerol)
- Methadone (Dolophine)
- Methohexital
- Midazolam (Versed)
- Morphine
- Naloxone (Narcan)
- Nubain (Nalbuphine)
- Oxycodone
- Pentobarbital
- Phenobarbital
- Stadol (Butorphanol)
- Sufentanyl
- Talwin (Pentazocine)
- Thiopental
- Versed (Midazolam)

MD MMS2018

High Risk

- CT Scan w/ IV contrast
- Category D pregnancy medications
- Administration of moderate sedation
- Anticoagulation Therapy
- Physical restraints



MD MMS2018

Code	COPA	DATA	RISK
99281	N/A	N/A	N/A
99282	**Minimal** ☐ Self-limited or minor problem	☐ **Minimal or none**	☐ **There are currently no published examples for minimal risk.**
99283	**Low** ☐ 2+ self-limited or minor problems; ☐ Stable chronic illness; ☐ Acute, uncomplicated illness or injury ☐ Stable acute illness	☐ **Limited** - Satisfy at least one category **Category 1: Tests and documents** At least 2 from the following: ☐☐ Review of prior external note ☐☐ Review of the result(s) of each test ☐☐ Ordering of each test ☐ **Category 2: Assessment requiring an independent historian(s)**	☐ **There are currently no published examples for low risk.**
99284	**Moderate** ☐ Chronic illnesses with exacerbation/progression ☐ 2+ stable chronic illnesses; ☐ Undiagnosed new problem with uncertain prognosis; ☐ Acute illness with systemic symptoms; ☐ Acute complicated injury	☐ **Moderate** - Satisfy at least one category ☐ **Category 1: Tests, documents, or independent historian(s)** At least 3 from the following: ☐☐☐ Review of prior external note ☐☐☐ Review of the result(s) of each test ☐☐☐ Ordering of each test ☐☐☐ Assessment requiring an independent historian ☐ **Category 2: Independent interpretation of tests** ☐ **Category 3: Discussion of management or test interpretation**	**Moderate risk** Examples only: ☐ Prescription drug management ☐ Decision re: minor surgery w/risk factors ☐ Decision re: elective major surgery w/o risk factors ☐ Care limited by social determinants of health
99285	**High** ☐ Chronic illnesses with severe exacerbation/progression ☐ Illness or injury that poses a threat to life or function	☐ **Extensive** - Satisfy at least two categories ☐ **Category 1: Tests, documents, or independent historian(s)** At least 3 from the following: ☐☐☐ Review of prior external note ☐☐☐ Review of the result(s) of each test ☐☐☐ Ordering of each test ☐☐☐ Assessment requiring an independent historian ☐ **Category 2: Independent interpretation of tests** ☐ **Category 3: Discussion of management or test interpretation**	**High risk of** Examples only: ☐ Drug therapy requiring intensive monitoring for toxicity ☐ Decision re: elective major surgery w/risk factors ☐ Decision re: emergency major surgery ☐ Decision re: hospitalization or escalation of care ☐ Decision for DNR or de-escalate care ☐ Parenteral controlled substances

Save Clear

Level determined by reaching 2 out of 3 elements of MDM

MD MMS2018

TIME

- For coding purposes, time for these services is the total time on the date of the encounter.
- It includes time regardless of the location of the Qualified Health Professional (whether on or off the inpatient unit or outpatient office).
- It includes both face-to face and non-face-to-face activities with the patient and/or family.

TIME: What to Include?

- Preparing to see the patient (ex: review of labs)
- Obtaining and/or reviewing separately obtained history
- Performing a medically appropriate exam
- Counseling and educating the patient/family/caregiver
- Ordering medicines/tests/procedures
- Referring and communicating with other health care professionals (when not separately reported)
- Documenting clinical information in the EHR
- Independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
- Care coordination (not separately reported)

TIME: What to Exclude?

- The performance of other services that are reported separately
- Travel
- Teaching that is general, not limited to discussion that is required for the management of a specific patient.

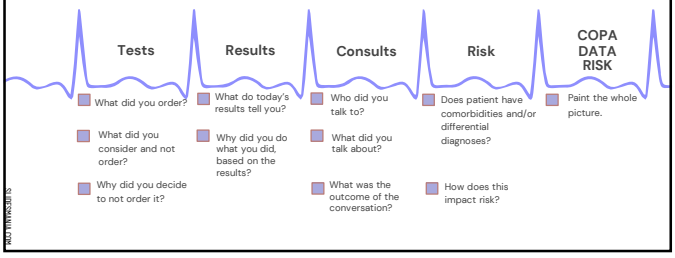
Split/Share

- Under Medicare, a service can only be billed by one clinician, and if non-physician practitioners bill for the service, they only receive 85% of the total Medicare rate.
- The Substantive portion is now quantifiable and can be determined in two ways: it is either based on the majority of the total clinical care time invested by the physician and the NPP; OR by the substantive portion of the MDM process.

What supports a Substantive Portion of MDM Process

- Personally perform and document independent interpretations.
- Discussion of management or test interpretation with external physician/QHP or appropriate source.

Remember to document your thought process.
How did you get from chief complaint to diagnosis?



ACU Advocates

Case Studies

ACU Advocates

Indicative of High COPA

Appropriate History

Basic Information
60-year-old female who reports a past medical history of hyperlipidemia and an endorsed prior heart attack in 2015 presenting with concern for acute onset chest pain today. Patient is traveling through to Indianapolis from Panama City where she was on vacation when she developed the chest pain today. The chest pain happened acutely about 10 minutes prior to arrival per report. It was associated with shortness of breath when it first happened. She was just sitting in the car when it happened. They had been in the car since about 10 AM this morning which is about 13 hours. She states they stopped multiple times to stretch on the way however. Denies history of blood clots or leg swelling. Currently not experiencing shortness of breath. She states it feels very similar to when she had a heart attack before in 2015 in West Virginia. No fevers no recent cough. Endorses history of hyperlipidemia as well. Unknown if chest pain is exertional or worsens with exertion but it is still hurting her currently.

ACU Advocates

Appropriate Examination

Gen: NAD
CV: RRR, No edema
Pulm: CTAB, Unlabored respirations
Abd: Soft, nondistended, epigastric abdominal tenderness to palpation.
MSK: No deformities
Neuro: A+Ox3, GCS 15, Moving all extremities spontaneously

60-year-old with chest pain

Vitals unremarkable on arrival

On exam there is some sternal tenderness to palpation. There is also epigastric abdominal tenderness. Lungs good auscultation bilaterally. No obvious murmurs. Equal pulses in all extremities. No leg swelling.

ACU Advocates

EKG demonstrates what seems to be sinus rhythm though there is significant artifact with rate of about 69, a normal QRS and normal QTc. There is a normal axis. Again difficult to discern because of significant artifact in multiple leads but no obvious ST changes on initial EKG. No prior for comparison. Interpreted by me contemporaneously with care.

Independent Interpretations

Repeat EKG when patient roomed demonstrates normal sinus rhythm rate of 64 normal QRS and normal QTc. There is a slight left axis deviation. There are inverted T waves in leads V1, V2, V3. No significant ST elevations or depressions. No prior for comparison. Interpreted by me contemporaneously with care.

Patient's initial history is concerning for cardiac chest pain. Her initial EKG does not show a STEMI which is reassuring however we will treat her anginal chest pain currently with the nitroglycerin now while obtaining further workup.

Independent Interpretation

Chest x-ray demonstrates no obvious pneumothorax or consolidation on my interpretation. Radiologist report below.

Labs today demonstrate transaminitis AST greater than doubled suggesting alcohol which is likely from her recent visit to Panama. When I asked her she says she only had 1 margarita a few days ago and is not a big drinker otherwise.

Prescription Drug Management

After nitroglycerin, patient's pain brought down from 10 to a 7.

Labs reviewed

Lipase within normal limits. Magnesium slightly low which was repleted in the ED. Troponin negative.

AED MANAGER

Medical Decision Making
Documents reviewed: Prior records.
Results review: **Labs Last 30 Days**
Chemistry
Sodium Level: 138 mmol/L (03/31/24 00:59:00)
Chloride Level: 109 mmol/L (03/31/24 00:59:00)
Blood Urea Nitrogen: 16 mg/dL (03/31/24 00:59:00)
Carbon Dioxide Level: 20 mmol/L Low (03/31/24 00:59:00)
Potassium Level: 3.6 mmol/L (03/31/24 00:59:00)
Creatinine Level: 1 mg/dL (03/31/24 00:59:00)
Glucose Level: 100 mg/dL (03/31/24 00:59:00)
Calcium Level: 9 mg/dL (03/31/24 00:59:00)
Magnesium Level: 1.8 mg/dL Low (03/31/24 00:59:00)Albumin Level: 4.3 Gram/dL (03/31/24 00:59:00)
Alk Phos: 62 Units/Liter (03/31/24 00:59:00)
ALT: 99 Units/Liter High (03/31/24 00:59:00)
AST: 197 Units/Liter High (03/31/24 00:59:00)
Bilirubin Total: 0.6 mg/dL (03/31/24 00:59:00)
Protein Total: 6.3 Gram/dL Low (03/31/24 00:59:00)**Hematology**
WBC: 7 x10(3)/uL (03/31/24 00:59:00)
MCV: 99.4 fL High (03/31/24 00:59:00)
Hgb: 13.9 Gram/dL (03/31/24 00:59:00)
Hct: 40.4 % (03/31/24 00:59:00)
Platelet Count: 190 x10(3)/uL (03/31/24 00:59:00)
PT: 12.7 Second(s) (03/31/24 00:59:00)
PTT: 30.6 Second(s) (03/31/24 00:59:00)
INR: 1.11 (03/31/24 00:59:00) No qualifying data available..
Radiology results: No Radiology Results Found.

Labs reviewed

AED MANAGER

Heart Score
History
- Moderately Suspicious 1
EKG
- Nonspecific repolarization disturbance 1
Age
- 45-64 1
Risk Factors
- Greater than 2 risk factors or known atherosclerotic disease 2
Troponin
- normal limit 0
Total 5

Test Reviewed

Considering heart score and chest pain which has concerning features for possibly unstable angina I think it is reasonable for admission to chest pain observation unit considering otherwise normal workup.

Decision to escalate care

I spoke with Dr. J about the patient's presentation and my concern for anginal chest pain and he is agreeable to admit the patient to clinical decision unit overnight for stress test.

Discussion with another provider

Stable throughout ED course and placed in CDU in stable condition.

Decision to Admit

AED MANAGER

Code	COPA	DATA	RISK
	N/A	N/A	N/A
99281	**Minimal**	Minimal or none	There are currently no **published examples for minimal risk.**
	self-limited or minor problem		
99283	**Low**	**Limited** - Satisfy at least one category	There are currently no **published examples for low risk.**
	2+ self-limited or minor problems;	**Category 1: Tests and documents**	
	Stable chronic illness;	At least 2 from the following:	
	Acute, uncomplicated illness or injury	Review of prior external note	
	Stable acute illness	Review of the result(s) of each test	
		Ordering of each test	
		Category 2: Assessment requiring an independent historian(s)	
99284	**Moderate**	**Moderate** - Satisfy at least one category	**Moderate risk**
	Chronic illnesses with exacerbation/progression		Examples only:
	2+ stable chronic illnesses;	**Category 1: Tests, documents, or independent historian(s)**	Prescription drug management
	Undiagnosed new problem with uncertain prognosis;	At least 3 from the following:	Decision re: minor surgery w/risk factors
	Acute illness with systemic symptoms	Review of prior external note	Decision re: elective major surgery w/o risk factors
	Acute complicated injury	Review of the result(s) of each test	Care limited by social determinants of health
		Ordering of each test	
		Assessment requiring an independent historian	
		Category 2: Independent interpretation of tests	
		Category 3: Discussion of management or test interpretation	
99285	**High**	**Extensive** - Satisfy at least two categories	**High risk of**
	Chronic illnesses with severe exacerbation/progression	**Category 1: Tests, documents, or independent historian(s)**	Examples only:
	Illness or injury that poses a threat to life or function	At least 3 from the following:	Drug therapy requiring intensive monitoring for toxicity
		Review of prior external note	Decision re: elective major surgery w/risk factors
		Review of the result(s) of each test	Decision re: emergency major surgery
		Ordering of each test	Decision re: hospitalization or escalation of care
		Assessment requiring an independent historian	Decision for DNR or de-escalate care
		Category 2: Independent interpretation of tests	Parenteral controlled substances
		Category 3: Discussion of management or test interpretation	

Save Clear

MDM Grid

High COPA
Extensive Data
High Risk

Supports 99285
Level of Service

AED MANAGER

History of Present Illness
4-year-old female. Chief complaint of right ear pain. Present for the past hour and a half. Patient's father states that she has been behaving normally. Eating and drinking normally. She has been producing urine without difficulty. No rash. No cough.

History from an Independent Historian

General: Alert, no acute distress.
Skin: Warm, dry, intact, no rash.
Head: Normocephalic, atraumatic.
Neck: Supple, trachea midline.
Eye: Pupils are equal, round and reactive to light, extraocular movements are intact.
Ears, nose, mouth and throat: Oral mucosa moist, no pharyngeal erythema or exudate, R Tm has purulent effusion, L TM Clear
No post-auricular tenderness, erythema, or swelling .
Cardiovascular: Regular rate and rhythm, No murmur, Normal peripheral perfusion.
Respiratory: Lungs are clear to auscultation, respirations are non-labored.
Musculoskeletal: Normal strength, no swelling, no deformity.
Neurological: No focal neurological deficit observed, normal speech observed.
Psychiatric: Cooperative, appropriate mood & affect.
no tragus tenderness, no "boggy" auditory canal

Appropriate History an Examination

AKO INVASIVE

Medical Decision Making
Differential Diagnosis: Otitis media, otitis externa, swimmer's ear.

Acute Uncomplicated Illness

Acute Complaint: see hpi
Hx obtained from: pt's father
comorbidities: none
Discussions of procedures/medications w/ pt: discussed abx and ibuprofen.
given amoxicillin and ibuprofen in ED
Economic/social factors: Pt's family is appropriately supportive and reliable for followup
ED course: HDS in ED without any acute events
Discussed that early on in a disease, symptoms may be mild and new or more severe symptoms can arise. Cautioned that if this happened, patient should return to the ED immediately

no evidence of mastoiditis on exam. pt appears well and nontoxic. She is playful and mentating appropriately.

AKO INVASIVE

Impression and Plan
Diagnosis
Otitis media of right ear - Discharge, Medical
Plan
Condition: Stable.
Prescriptions: Prescription Writer
Pharmacy:
amoxicillin 400 mg/5 mL oral liquid (Prescribe): 45 mg/kg, Oral, Q12H, for 10 Day(s), pt weight 18.6 kg. Fill to quant sufficient., 1 Each, 0 Refill(s).

Prescription Drug Management

AKO INVASIVE

Code	COPA	DATA	RISK
99281	N/A	N/A	N/A
99282	**Minimal** ☐ self-limited or minor problem	☐ **Minimal or none**	☐ **There are currently no published examples for minimal risk.**
99283 ☑	**Low** ☐ 2+ self-limited or minor problems; ☐ Stable chronic illness; ☑ Acute, uncomplicated illness or injury ☐ Stable acute illness	☐ **Limited** - Satisfy at least one category **Category 1: Tests and documents** At least 2 from the following: ☐☐☐ Review of prior external note ☐☐☐ Review of the result(s) of each test ☐☐☐ Ordering of each test ☐ **Category 2: Assessment requiring an independent historian(s)**	☐ **There are currently no published examples for low risk.**
99284	**Moderate** ☐ Chronic illnesses with exacerbation/progression ☐ 2+ stable chronic illnesses; ☐ Undiagnosed new problem with uncertain prognosis; ☐ Acute illness with systemic symptoms; ☐ Acute complicated injury	☐ **Moderate** - Satisfy at least one category ☐ **Category 1: Tests, documents, or independent historian(s)** At least 3 from the following: ☐☐☐ Review of prior external note ☐☐☐ Review of the result(s) of each test ☐☐☐ Ordering of each test ☐☐ Assessment requiring an independent historian ☐ **Category 2: Independent interpretation of tests** ☐ **Category 3: Discussion of management or test interpretation**	Moderate risk Examples only: ☐ Prescription drug management ☐ Decision re: minor surgery w/risk factors ☐ Decision re: elective major surgery w/o risk factors ☐ Care limited by social determinants of health
99285	**High** ☐ Chronic illnesses with severe exacerbation/progression ☐ Illness or injury that poses a threat to life or function	☐ **Extensive** - Satisfy at least two categories ☐ **Category 1: Tests, documents, or independent historian(s)** At least 3 from the following: ☐☐☐ Review of prior external note ☐☐☐ Review of the result(s) of each test ☐☐☐ Ordering of each test ☐☐ Assessment requiring an independent historian ☐ **Category 2: Independent interpretation of tests** ☐ **Category 3: Discussion of management or test interpretation**	High risk of Examples only: ☐ Drug therapy requiring intensive monitoring for toxicity ☐ Decision re: elective major surgery w/risk factors ☐ Decision re: emergency major surgery ☐ Decision re: hospitalization or escalation of care ☐ Decision for DNR or de-escalate care ☐ Parenteral controlled substances Save Clear

MDM Grid

Low COPA
Limited Data
Moderate Risk

Supports 99283 Level of Service

AKO INVASIVE

If you Think it, Ink it!

Document what you Do,
Do what you Document.

Thank you!

If you have any questions please feel free to email me at:

Leslie.kaelin.1@louisville.edu