American Academy of Child and Adolescent Psychiatry

CPT CODE TRAINING MODULE

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NOT FOR CITATION

(CPT changes so rapidly that by the time this module is printed, it may be outdated)

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INTRODUCTION

HISTORY AND CONTEXT OF CPT

Background

In the beginning, there was fee for service, whether barter or cash. During World War II, Congress imposed price and wage freezes. Orders for manufactured goods (material for the war effort) were increasing and companies were short on labor. They needed to recruit. Without ability to raise wages to attract workers, what was to be done?

Business came up with the idea of BENEFITS. Benefits included vacation, pension and agreement to help pay for medical expenses (*health insurance)*. Companies could offer improved benefit packages and workers would come to work for them. The concept of employer's paying for medical insurance grew rapidly.

Twenty years later, Medicare was enacted (1965) and implemented 1967. Healthcare expenses rose. So did employer's cost of paying for health insurance and healthcare expenditure nationally. While other developed countries devoted no more than 5% of their Gross Domestic Product to health care, the United States was spending no less than 10% on its healthcare. By the 1970's, health benefits added $500 to the cost of every automobile made in this country. Now, American car companies spend more per car on health care than steel. (Hakim, 2005)

Congress's Solution

The Health Care Finance Administration (HCFA) was established within the Department of Health and Human Services of the Federal government to rein in the spiraling costs of administering Medicare. HCFA's charge was to:

- ✓ Control expenses.
- ✓ Guarantee that the services billed and paid for are the ones that were delivered. For example, if HCFA paid for an adolescent in an acute psychiatric bed, the adolescent must have received documented acute care, as opposed to residential or custodial care. Or, if HCFA pays for a comprehensive outpatient examination, the examination must have been truly comprehensive, with documented evidence that it was different from a less thorough examination.
- ✓ Adopt procedure codes to accurately describe medical procedures. HCFA choose the Current Procedural Terminology (CPT) codes developed by CPT Editorial Board of the American Medical Association. (In 1992 many private insurance companies began using them as well and they are now the gold standard for procedure coding.)
- ✓ Assign reimbursement values for each CPT code, based on interpretation of Congressional mandates. To assist them in the process, Congress authorized development of The Resource-based Relative-value Scale (RBRVS) (Hsiao, 1987). Currently, Medicare payment to physicians is based on the RBRVS.

Unlike many other developed countries, in the United States private companies assumed responsibility for parts of the social safety net: health care and retirement. Elsewhere, government takes primary responsibility for these services.

In the 1970s, Congress wanted to encourage insurance companies to offer health insurance programs and pension plans (Employee Benefit Plans) to companies. President Ford signed the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provided:

- ✓ Federal, not state control of pension funds
- ✓ Exemption of insurance companies from lawsuit
- ✓ Assign fiduciary responsibility to funds administrator, even if it is the insurance company.

Because of the fiduciary's need to maintain pension fund's solvency and because healthcare cost had an increasing impact on the company's bottom line, fund administrators became more critical and selective when purchasing health care coverage. Through ERISA, companies had the authority to determine what health care services, packages and limitations their employees could receive, without risk of lawsuit against them or the insurance company.

Before ERISA, insurance companies had to make good faith effort to settle claims or face lawsuit. ERISA changed the liability standard from "bad faith" to "arbitrary and capricious." Even if this higher standard is met, no punitive damages could be awarded. In addition, before filing a claim, the claimant must first exhaust all administrative appeals (internal) to obtain a settlement. The settlement cannot exceed what the insurance company would have to pay if the claim had originally been approved (no punitive damage). The settlement does not include attorney fees for this administrative process; they are the claimant's responsibility.

Going into the 1992 Presidential elections, healthcare "reform" was a major issue for both George H.W. Bush and Clinton. The Jackson Hole Group advised both candidates. Systems of managing care were recommended. Initially, managed care imposed tight restrictions. Recently, they have loosened their grip. Of note is that Congress has failed to pass any major health care legislation during the George H.W. Bush, Clinton and George W. Bush presidencies except for the Medicare Drug Bill. The Patient Bill of Rights introduced in 1997 still has not been passed. At this time, healthcare has been tabbed as President Obama's number 1 domestic priority, but it remains far from certain whether Congress will approve any changes.

Politics aside, since the early 1980s, physicians have been paid by procedure, whether office visit or surgical. Instead of basing payments to physicians on charges, HCFA paid according to a standardized payment schedule based on the resource costs and physician work needed to provide each service – Relative Value Units.

THREE COMPONENTS OF RELATIVE VALUE UNITS (RVUs)

Three components determine the cost of providing a service:

- ✓ physician work
- ✓ practice expense
- ✓ professional liability insurance expense

The sum of these 3 components (work units + practice expense units + malpractice expense units) yields the relative value unit (RVU). The RVU is then multiplied by a ***conversion factor*** (a monetary figure determined by CMS) and adjusted for geographical variability to arrive at the payment. The 2007 conversion factor was 37.8975 and was scheduled for a -10.6% change; the final vote replaced the change with a 0.5% increase retroactive to July 1, 2008. The 2009 conversion factor is about 36.

Relative value units are assigned to CPT codes by CMS after receiving recommendations from the Relative-Value Update Committee (RUC) of the AMA. The RUC's recommendations are based on the presentation of the specialty society that requests the code valuation. The RUC has 28 members. These physicians, along with a representative from allied medical fields, arrive at specific work and practice expense values that are then sent to CMS for review and publication in the Federal Register.

What was the impact over the first 16 years? Healthcare expenditures increased to 16% of the GDP. It had increased at a slower rate during the early 1990s, but no longer. Healthcare expense as a percent of GDP has risen from 5% in 1960 to 16% in 2007. (By comparison, Germany spends less than 8% of its GDP on healthcare.)

	1990 ($billions)	**2006 ($billions)**
National Health		
Expenditure	**714**	**2 105.5**
Private	**427.3**	**1 135.2**
Public	**286.7**	**970.3**
Gross Domestic		
Product	**5 803**	**13 195**
Private Health Insurance		
Premiums	**233.7**	**723.4**
Benefit paid	**204.6**	**634.8**
Net	**29.1 (13%)**	**88.8 (13%)**

SOURCE: Center for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, 2008.

The RUC elects someone to sit in its 2-year non-internal medicine rotating seat. Sherry Barron-Seabrook, M.D. is our current RUC Adviser. In addition, AACAP participates in surveys of its members to determine the most realistic figures for physician work and practice expense for each

service. In 1997, AACAP administered a survey for the 908XA, a series of codes adopted by HCFA on January 1 1997, as G codes. Working with the American Psychiatric Association, American Nurses Association, American Psychological Association, and the National Association of Social Workers, AACAP helped forge a consensus recommendation for these codes, which were recommended by the RUC for HCFA's adoption. HCFA published its decision in the *Federal Register Final Rule* in November 1998. On June 14, 2001, HCFA's name was changed to the more descriptive Center for Medicare and Medicaid Services (CMS). CMS will be used throughout the remainder of the module.

Physician Work

The physician work component accounts, on average, for 54% of the total relative value for each service. The factors used to determine physician work include:

- ✓ the amount of physician time involved
- ✓ the technical skill and physical effort required
- ✓ the mental effort and judgment required
- ✓ the stress to the physician resulting from potential risk to the patient from the procedure

Practice Expense

The RUC has completed assigning Practice Expense (PE) RVUs to extant codes. Practice expense RVUs account for an average of 41% of the total value for each service. The RUC established a Practice Expense Advisory Committee (PEAC) in February 1999. Along with the American Psychiatric Association, Sherry Barron-Seabrook, M.D. presented PE data from the AACAP to the PEAC in August, 2001. These PE values reflected office costs like play equipment, rent, utilities, billing expenses, etc. Since 2004, all new or revised codes presented to the RUC must include both work and PE values. The RUC will then recommend a specific value for each to CMS.

Professional Liability Cost

The professional liability cost component is derived from a formula. In 2009, CMS noted that Allergy and Immunology replaced psychiatry as the specialty with the lowest malpractice cost

Scope of CPT and RUC

CPT codes and the reimbursement values assigned to them are, strictly speaking, applicable only to services billed to Medicare through any of its regional carriers. Private payers choose whether to use the codes and reimbursement values adopted by CMS for the procedures they reimburse. AACAP members must query each insurance carrier directly regarding the extent to which it adheres to the CMS values for each CPT code.

FRAUD AND ABUSE

The only legal way to be paid for a service is to bill using the correct CPT code. You also must document that the level of service claimed was delivered. Prior to 1996 there was no distinction between fraud and sloppy billing practices. In 1996, the standard of "intent to knowingly and willingly deceive" was adopted, but if one consistently billed incorrectly and had no audit system to find and correct billing errors, one may be vulnerable to this standard.

False Claims – billing for services not provided.

Up coding

Examples: Coding a 90805 when seeing a patient for 20 minutes (or coding 90805 for 3 visits in an hour). Coding 90214 while documentation supports a lower level of service.

Code edits

Billing codes that do not belong together (Correct Coding Initiative – CCI)

Examples: Coding 2 services when one of the codes billed includes the other service – coding 90805 AND 90862 for the same visit.
Violating AdminiStar software program – most edits involve surgical procedures like separate billing for amputation of digits and foot when performing a below the knee amputation. Currently, there are over 3,600 edits for the 90000 code series including 2048 psychiatry code pairs; e.g. 90801 and 90802, 90801 and 99291, 90801 and 99292. (http://cms.hhs.gov/physician/cciedits/default.asp)

Medically Unlikely Edits (MUE)

Codes that are *unlikely* to be billed together. These edits may be appealed on a case-by-case basis. Originally, the edits were "medically unbelievable," but because of physician objection, the term "unlikely" was substituted for "unbelievable."

Examples: 2 90805's for the same patient on the same day, or 2 90801's for the same patient on the same day, etc. Medicare rules prohibit billing more than 1 psychiatry code per patient per day.

Kennedy-Kassebaum (1996):

- ✓ Added "knowingly and willingly" standard to false claims legislation. Before 1996, physicians could be accused of violating the law if they simply made a mistake. Now, the standard is "knowingly and willingly," BUT that does NOT imply ignorance of coding rules is a credible defense for coding errors.
- ✓ Made "falsifying" a private claim a federal offense like falsifying a Medicare/Medicaid claim.
- ✓ Added 700 investigators to the Inspector General's office at CMS.
- ✓ Fines collected support the salaries of the investigators.
- ✓ Example: Instructing one's billing agent to code 90805 for any brief visit is a knowing and willing action that could place the physician at risk if the level of

service does not meet 90805 criteria (20 to 30 minutes with additional time for the E/M component).

- ✓ Physician is responsible (and liable) for all coding done in that physician's name.

Consequences:

- ✓ Pay damages up to 3 times the amount of the claim.
- ✓ Mandatory penalties of $5,000 to $10,000 per claim, regardless of the size of the claim.
- ✓ The Investigator General's office receives a return of about $20 for each $1 used to fund an investigation. That return is used to support the salary of the investigators.
- ✓ Whistle-blowers act in the name of the government and may seek the same damages. The Department of Justice may intercede and the realtor could still receive 15% to 25% of the claim. Realtor may proceed alone and keep up to 30% of the final recovery.

CODE CATEGORIES

The Health Insurance Portability and Accountability Act (HIPAA, 1996) required CMS to issue a request for proposals for alternative coding systems. The AMA realized that CPT needed to be changed and initiated the CPT 5 project to develop necessary modifications. In August 2000, CMS announced that it would continue to use CPT as the coding system for medical procedures for Medicare patients. Two additional code categories debuted in CPT 2002 (see below).

Category I: these are the current procedure codes. All of the E/M and psychiatry codes are included in Category I.

Category II: These are OPTIONAL codes designed for physicians and/or auditors to track certain services that various agencies (e.g. HCQA) have determined contribute to quality care and good outcomes. They include performance measures like diabetic foot exam or the initiation of an anti-arrhythmia drug after a heart attack. These quality measures may also be used to determine Pay for Performance reimbursement, currently being considered by private payers. These are 5 digit codes with an "F" occupying the fifth digit slot, e.g. 1234F.

In CPT 2009, there are 18 potentially relevant Category II codes:

- Patient History: 1040F DSM IV criteria for Major Depressive Disorder (MDD) documented
- Physical Examination: 2014F Mental status assessed
- Screening Process:
  - 3011F Lipid panel results documented and reviewed at initial evaluation
  - 3085F Suicide risk assessed
  - 3088F MDD mild
  - 3088F MDD moderate
  - 3090F MDD severe without psychotic features
  - 3091F MDD severe with psychotic features
  - 3092F MDD in remission
  - 3093F Documentation of new diagnosis of initial or recurrent episode of MDD
- Therapeutic, Preventive or Other Interventions
  - 4000F Tobacco use cessation intervention counseling
  - 4001F Tobacco use cessation intervention pharmacologic therapy
  - 4060F Psychotherapy service provided (MDD)
  - 4062F Patient referral for psychotherapy documented (MDD)
  - 4064F Antidepressant pharmacotherapy prescribed (MDD)
  - 4065F Antipsychotic pharmacotherapy prescribed (MDD)
  - 4066F ECT provided (MDD)
  - 4067F Patient reviewed for ECT documented (MDD)

HEDIS measures that could become Category II codes for attention deficit disorder are currently being considered.

Other HEDIS measures:

Immunizations by age 2

Immunization completed by age 3
Mammography within 2 years for ages 52 – 69
First trimester prenatal care
Post partum check ups
Eye exams for diabetics within 1 year
Outpatient follow-up within 30 days after hospitalization for mental disorder

May use –28 modifier if not appropriate; e.g. diabetic foot exam for amputee

Category III: These are TEMPORARY codes for new and emerging technologies. They may be covered by given carriers if you personally arrange for that. They are not covered by Medicare. The rTMS procedure has applied for a category III code. If these codes are not assigned a category I code within 5 years, they will be retired. These codes are 5 digits with a "T" occupying the fifth digit slot - e.g. 1234T.

In summary, "regular" CPT codes are grouped as Category I codes in this edition of CPT. Two other code categories are also included in the book. Category II codes are used to track performance measures like eye exam or foot exam, which may be part of another general examination (they rely heavily on HEDIS measures) and are optional. Category III codes are used to track new and emerging technologies. You must negotiate directly with the insurance carrier for payment. They are not part of the Medicare payment system.

FUTURE CONSIDERATION

Congress has mandated that CMS review the RBRVS every 5 years. This process allows the RUC and specialty societies like the AACAP to make a case to revalue codes. One must first present "compelling evidence" that a code is erroneously valued, and then provide data to support a new RVU. That data will come from surveys of practitioners who use the code(s).

The Healthcare Access and Economics Committee believes the psychiatric codes are undervalued and is working with psychologists (American Psychological Association), social workers (National Association of Social Workers), nurses (American Nursing Association), and general psychiatrists (American Psychiatric Association) to re survey our codes. In spring, 2010, you may receive a survey in the mail. PLEASE COMPLETE AND RETURN IT. If you have questions, please contact any member of this committee.

The 5-year review is the mechanism to address the undervaluing of our work and increase payment. Please participate in this process.

New Coding:

99367: Medical Team Conference without patient present. The RUC has recommended work and practice expense values for CMS to consider in the Final Rule for 2008. However, in order for this code to pass the RUC, specific criteria were adopted:

1. Three different disciplines must be present at the team conference.
2. Each member of the team must have examined the patient, face to face, within the past 60 days.

3. The discussion must last at least 30 minutes per patient.
4. No more than 1 member of the same specialty may report this code on the same day.

One can use other Evaluation and Management Codes for team meetings if the patient is present. Time would be the determining factor as discussed below in the E/M section of the module.

Non-physician attendees (e.g. social workers, dietitians, psychologists, occupational therapists, physical therapists, etc) may bill using code 99366 if the patient is PRESENT or 99368 if the patient and/or caregiver is NOT PRESENT.

99241-99245, 99251-99255: Consultation Codes. CMS is considering ELIMINATING all consultation codes. The AACAP and the AMA have commented in OPPOSITION to this proposed rule. CMS announces its decision in the Final Rule of the Federal Register in November, 2009. At this time (October 2009), all consultations are limited to a single patient encounter (either outpatient – 9924x or inpatient – 9925x) and have 5 levels of complexity. Use other E/M codes to report what used to be (prior to 2006) follow-up or other consultations.

DOCUMENTATION

It is important to note that no service has been provided unless it has been documented. If a service is not documented, it might as well never have been performed from the point of view of any third party reviewers who are providing payment. The government has increased financial support for "watchdogs" who investigate providers. These investigators from CMS's Inspector General's office look for fraud and abuse in billing by examining documentation of medical services (your patient's charts).

PRINCIPLES OF DOCUMENTATION FOR CPT

- ✓ **The medical record should be complete and legible.**
- ✓ **The documentation of each patient encounter should include: reason for the encounter and relevant history, physical examination findings and prior diagnostic tests; assessment, clinical impression or diagnosis; plan for care; and date and legible identity of the observer.**
- ✓ **If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.**
- ✓ **Past and present diagnoses should be accessible to the treating and/or consulting physician.**
- ✓ **Appropriate health risk factors should be identified.**
- ✓ **The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented.**
- ✓ **The CPT and ICD-9 codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.**

Source: CMS and AMA publication BPO-B12, May 1997

With input from the AMA and Specialty Societies, CMS is revising the E/M (Evaluation/ Management) documentation requirements. Until the new requirements are adopted, physicians may use either the 1994 (general multi-system examination) or 1997 (single system examination) guidelines. We discuss the 1997 guidelines below.

EVALUATION AND MANAGEMENT SERVICES (99xxx)

Evaluation and Management (E/M) services constitute nearly one-third of all services reported by physicians (Udell, et al., 1996). E/M codes describe office, hospital, consultative, nursing home, and related "visit" services. The exact codes are determined by the combination of different levels of history taking, examination, and medical decision-making performed by a physician.

The following components are used to determine the level of E/M service:

- ✓ History
- ✓ Examination
- ✓ Medical Decision-Making
- ✓ Counseling
- ✓ Coordination of Care
- ✓ Nature of Presenting Problem
- ✓ Time

Of these, the first three (history, examination, and medical decision-making) are the **key** components in selecting the level of E/M services. In the case of visits that consist predominantly of counseling and/or coordination of care, ***time*** is the key or controlling factor to qualify for a particular level of E/M service.

In general, the level of initial E/M service is dependent on performance and documentation of all three key components and follow-up E/M services depend on two of three key components.

Each of the seven components of E/M services is described in detail in the sections that follow.

HISTORY

⇐⇐⇐**History**
Examination
Medical Decision-Making
Counseling
Coordination of Care
Nature of Presenting Problem
Time

The levels of E/M services are based on four levels of history (Problem-Focused, Expanded Problem-Focused, Detailed, and Comprehensive). Each type of history includes some or all of the following elements:

- ✓ Chief complaint (CC);
- ✓ History of present illness (HPI);
- ✓ Review of systems (ROS); and
- ✓ Past, family, and/or social history (PFSH).

History may be gathered from the patient, the patient's parents, and other sources (e.g. school, court referral source, and social services agencies). Parent and patient questionnaires and standardized interviews are acceptable. The work-ups of residents or physician extenders also are acceptable, but the physician must certify their authenticity and/or record changes and differences of opinion.

The extent of history of present illness, review of systems, and past, family, and/or social history that is obtained and documented is dependent on clinical judgment and the nature of the presenting problem(s).

LEVELS OF HISTORY

All levels of history include the chief complaint. The completeness of the other three components of history-taking determines the overall level of history.

COMPONENTS OF HISTORY

Level of History	History of Present Illness	Review of Systems	Past, Family, and Social History
Problem-Focused	Brief	Not Required	Not Required
Expanded Problem-Focused	Brief	Problem-Pertinent	Not Required
Detailed	Extended	Extended	As pertains to problem
Comprehensive	Extended	Complete	Complete

CHIEF COMPLAINT

The chief complaint (CC) is a concise statement describing the symptom, problem, condition, diagnosis, physician recommended return, or other factor that is the reason for the encounter, usually stated in the patient's words. The medical record should clearly reflect the chief complaint.

HISTORY OF PRESENT ILLNESS

The history of present illness (HPI) is a chronological description of the development of the patient's present illness from the first sign and/or symptom or from the previous encounter to the present. It includes one or more of the following elements:

- ✓ location
- ✓ quality
- ✓ severity
- ✓ duration
- ✓ timing
- ✓ context
- ✓ modifying factors
- ✓ associated signs and symptoms

A **brief** HPI consists of 1 to 3 elements of the complete HPI.
An **extended** HPI consists of at least 4 elements of the complete HPI, or the status of at least 3 chronic or inactive conditions.
The medical record should describe the appropriate number of elements of the HPI.

REVIEW OF SYSTEMS

The review of systems (ROS) is an inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms that the patient may be experiencing or has experienced. For the purposes of CPT, the following systems are recognized (CPT, 2007):

- ✓ Constitutional symptoms (fever, weight loss)
- ✓ Eyes
- ✓ Ears, nose, mouth, and throat
- ✓ Cardiovascular
- ✓ Respiratory
- ✓ Gastrointestinal
- ✓ Genitourinary
- ✓ Musculoskeletal
- ✓ Integumentary (skin and/or breast)
- ✓ Neurological
- ✓ Psychiatric
- ✓ Endocrine
- ✓ Hematologic/lymphatic
- ✓ Allergic/immunologic

ROS can be performed at three levels, from least to most comprehensive.

Least Comprehensive		**Most Comprehensive**
Problem-Pertinent ⇐	**Extended Problem-Pertinent ⇐**	**Complete**

Problem-Pertinent System Review
The review covers:
- ✓ The (**one**) system directly related to problem identified in the history of present illness (HPI).

The patient's positive responses and pertinent negatives for the system related to the problem should be documented.

Extended Problem-Pertinent System Review
The review covers:
- ✓ **Two to 9** systems, including the system related to the problem identified in the HPI and a limited number of additional systems.

The patient's positive responses and pertinent negatives for two to nine systems should be documented.

Complete System Review
The review covers:
- ✓ At least **10** systems, including the system related to the problem identified in the HPI plus all additional body systems.

Those systems with positive responses and pertinent negatives must be individually documented. For the remaining systems, a notation indicating "all other systems are negative" is permissible. In the absence of such a notation, at least 10 systems must be individually documented.

Physicians can add to or accept data from another physician by noting changes in the ROS, and the date and location of earlier ROS.

PAST, FAMILY, AND/OR SOCIAL HISTORY

The Past, Family, and/or Social history (PFSH) consists of three areas:
- ✓ Past history (the patient's past medical experiences)
    - major illnesses and injuries
    - hospitalizations
    - surgeries
    - current medications
    - allergies
    - immunization status
    - dietary status

- ✓ Family history (a review of medical events in the patient's family, including diseases that may be hereditary or place the patient at risk); health status or cause of death of parents, siblings
- ✓ Social history (an age-appropriate review of past and current activities)
    - school behavior and academic achievement
    - living arrangements
    - parental separation, divorce
    - foster or adoptive status
    - current living arrangement
    - sexual history
    - trauma history
    - substance use history

For certain categories of E/M services that include only an interval history, it is not necessary to record information about the PFSH. Those categories are subsequent hospital care, follow-up inpatient consultations, and subsequent nursing facility care.

Past, Family, and Social History are defined by two levels, pertinent and complete.

Pertinent Past, Family, and Social History
A **pertinent** PFSH is a review of the history area(s) directly related to the problem(s) identified in the HPI. At least one specific item from any of the three histories (past, family, social) must be documented.

Complete Past, Family, and Social History
A **complete** PFSH is a review of either 2 or all 3 of the PFSH history areas, depending on the category of E/M service. A review of all 3 history areas is required for services that by their nature include a comprehensive assessment or reassessment of the patient. A review of 2 of the 3 history areas is sufficient for other services.

At least one specific item from 2 of the 3 history areas must be documented for a complete PFSH for the following categories of E/M services:

- ✓ emergency department
- ✓ office or other outpatient services, established patient
- ✓ domiciliary care, established patient
- ✓ home care, established patient

At least one specific item from each of the 3 history areas must be documented for a complete PFSH for the following categories of E/M services:

- ✓ office or other outpatient services, new patient
- ✓ hospital observation services
- ✓ hospital inpatient services, initial care
- ✓ consultations
- ✓ comprehensive nursing facility assessments
- ✓ domiciliary care, new patient
- ✓ home care, new patient

PROBLEM-FOCUSED HISTORY

- ✓ chief complaint
- ✓ brief history of present illness or problem

Example: While interviewing a 17-year-old girl, the clinician obtains statements from her that she feels depressed and has felt that way since she broke up with her boyfriend six weeks ago.

EXPANDED PROBLEM-FOCUSED HISTORY

- ✓ chief complaint
- ✓ brief history of present illness or problem
- ✓ problem-pertinent system review

Example: While interviewing the same patient, the clinician obtains the above statements from her, and that she has had a sleep disturbance for three weeks, appetite loss for 10 days, and that the fun has disappeared from life for the past several days.

DETAILED HISTORY

- ✓ chief complaint
- ✓ brief history of present illness or problem
- ✓ problem-pertinent system review extended to include a review of a limited number of additional systems
- ✓ pertinent past, family, and/or social history directly related to the patient's problems

Example: While interviewing the same patient, the clinician obtains the above statements from her, and that she felt depressed three years ago, but it resolved without intervention; that her mother had a post-partum depression and required ECT eleven years ago; that her concentration has deteriorated with a decline in her grades. The system review includes nausea, constipation, decreased energy, and slowed movement. The impact of the presenting problem on the patient, as well as prior interventions, should be included.

COMPREHENSIVE HISTORY

- ✓ chief complaint
- ✓ extended history of present illness or problem
- ✓ problem-pertinent system review extended to include a review of systems that are directly related to the problem(s) identified in the history of the present illness, plus a review of all additional body systems
- ✓ complete past, family, and/or social history

Example: While interviewing the same patient, the clinician obtains the above statements from her, and also inquires in greater depth about her school functioning, social functioning, developmental history, and family history. The clinician asks and records a complete review of systems; inquiring about fever, weight loss, energy, vision, hearing, mouth, teeth, heart, dizziness, swelling, shortness of breath, skin lesions, menstrual history, pain/burning on urination, etc. These requirements are probably less rigorous than a moderately complete case study *without* the mental status examination (discussed below).

EXAMINATION

History
⇐⇐⇐**Examination**
Medical Decision-Making
Counseling
Coordination of Care
Nature of Presenting Problem
Time

A general multi-system examination or a single organ system examination may be performed by any physician regardless of specialty. The type (general multi-system or single organ system) and content of the examination are selected by the examining physician and are based on clinical judgment, the patient's history, and the nature of the presenting problem (AMA & HCFA, 1997).

A review and acceptance of examinations performed by competent others can suffice for documented portions of examinations not performed by the physician (AMA & HCFA, 1997), but attending physicians ***must repeat*** and document key elements of the examination.

Examination can be either general multi-system, or single-system for the following organ systems:

- ✓ cardiovascular
- ✓ ears, nose, mouth, and throat
- ✓ eyes
- ✓ genitourinary
- ✓ hematologic/lymphatic/immunologic
- ✓ musculoskeletal
- ✓ neurological
- ✓ psychiatric
- ✓ respiratory
- ✓ skin

General multi-system or single organ system examination can be performed at any of four levels.

- ✓ problem-focused
- ✓ expanded problem-focused
- ✓ detailed
- ✓ comprehensive

General Multi-System Examination

The General Multi-System Examination (1994 documentation standard) will not be discussed in this Module. See the current CPT for description.

Single-System Examination - Psychiatric - 1997

Each of the organ systems has its own "single system examination." Only the psychiatric single-system examination is presented here. Details of the other single-system examinations are available from the AMA (AMA & HCFA, 1997).

Single System Examination – Psychiatric

System/Body Area	Elements of Examination
Constitutional	• Measurement of any three of the following seven vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff) • General appearance of patient (e.g. development, nutrition, body habitus, deformities, attention to grooming)
Head and Face	
Eyes	
Ears, Nose, Mouth and Throat	
Neck	
Respiratory	
Cardiovascular	
Chest	
Gastrointestinal (abdomen)	
Genitourinary	
Lymphatic	
Musculoskeletal	• Assessment of muscle strength and tone (e.g., flaccid, cog wheel, spastic) with notation of any atrophy and abnormal movements • Examination of gait and station
Extremities	
Skin	
Neurological	
Psychiatric	• Description of speech, including: rate; volume; articulation; coherence; and spontaneity with notation of abnormalities (e.g., perservation, paucity of language) • Description of thought processes, including: rate of thoughts; content of thoughts (e.g., logical vs. illogical, tangential); abstract reasoning; and computation • Description of association (e.g. loose, tangential, circumstantial, Intact) • Description of abnormal or psychotic thoughts, including: hallucinations; delusions; preoccupation with violence; homicidal or

	suicidal ideation; and obsessions • Description of the patient's judgement (e.g., concerning everyday activities and social situations) and insight (e.g., concerning psychiatric condition) Complete mental status examination, including • Orientation to time, place and person • Recent and remote memory • Attention span and concentration • Language (e.g. naming objects, repeating phrases) • Fund of knowledge (e.g., awareness of current events, past history, vocabulary) • Mood and affect (e.g., depression, anxiety, agitation, hypomania, lability)

PROBLEM-FOCUSED EXAMINATION

Problem-focused examination includes performance and documentation of 1 to 5 elements identified by a bullet, whether in a box with a shaded or unshaded border.

Example: In evaluating a patient with depression, the clinician would address mood and affect (psychiatric organ system). "The patient is depressed as manifested by depressed mood, crying, and irritability."

Example: In evaluating a patient with mental retardation, the clinician would address cognitive ability. "The patient is mentally retarded as manifest by an IQ score that is two standard deviations below the mean on a standardized test."

EXPANDED PROBLEM-FOCUSED EXAMINATION

Expanded problem-focused examination includes performance and documentation of at least 6 elements identified by a bullet, whether in a box with a shaded or unshaded border.

Example: In evaluating a patient with depression, the clinician would address at least six areas affected by the condition. "The patient is depressed. Attention and concentration are impaired. She can only report 3 digits forward. Speech is slow, sparse, and diminished volume. The patient appears sad, but is appropriately dressed. Thinking is slowed, but abstract reasoning and computation are in tact. Suicidal ideation present with no plan."

Example: In evaluating a patient with mental retardation, the clinician would address at least six areas affected by the condition. "The patient is mentally retarded and examination of abstract reasoning and fund of knowledge reveals findings well below age-expected developmental level. Mood and affect are somewhat labile. The patient is oriented x3, recent and remote memory are intact. Judgment is impaired - patient does not understand nuance of social interaction."

DETAILED EXAMINATION

Detailed examination includes the performance and documentation of at least nine elements identified by a bullet, whether in a box with a shaded or unshaded border.

Example: In evaluating a patient with depression, the clinician would examine and comment on at least nine aspects of the patient's mental status. In addition to appearance, mood, attention and concentration, speech, abnormal thoughts and thought processes, the clinician also examines memory, orientation, and associations: "With prompts and encouragement, he is able to recall three of three items after five minutes. He repeats five digits forward and four backward before giving up. He is oriented x4. There is no evidence of loose, tangential, or circumstantial associations."

Example: In evaluating a patient with mental retardation, the physician should examine and comment on at least nine aspects of the patient's mental status. In addition to abstract reasoning, fund of knowledge, memory, judgment, orientation, and moods, the clinician also examines attention span and concentration, abnormal thoughts, and language: "The child can repeat only three digits forward and two backward. With encouragement and numerous repetitions, he recalled two of three items after five minutes. He is easily distracted, but attends well when given individual attention. He is not suicidal, homicidal or hallucinating. Language is simple, but he can name objects and repeat phrases."

COMPREHENSIVE EXAMINATION

Comprehensive examination includes performance of ***all*** elements identified by a bullet, whether in a box with a shaded or unshaded border. Documentation of every element in a box with a shaded border, and at least 1 element in a box with an unshaded border is expected.

Example: In evaluating a patient with depression, the physician must examine and comment on every area of the Single System Examination. Constitutional, orientation, memory, attention span and concentration, language, associations, mood and affect, speech, thought processes, abnormal thoughts, judgment and insight, fund of knowledge, and musculoskeletal need comment. "P-88, R-14, BP-110/70. The patient was preoccupied with sad stories regarding separation and loss. While language was normal, he spoke slowly and said his thoughts came slowly. He felt like life was not worth living and he had thoughts of ending his life. He had no specific plan. His judgment was impaired: he felt that no one liked him in spite of his being invited to peers' homes frequently. His fund of knowledge was age-appropriate. His motor activity was slowed. He slouched when he walked, and associated arm movements were diminished. He had some insight into his condition as he stated he knew something was wrong with him and he wanted to feel better. He added he thought he would feel better if his parents stopped fighting and moved back in together. His recent and remote memory were normal. He was orientated to time, person, and place. His attention span and concentration were impaired as he was unable to perform serial 3's from 20 or spell 'cake' backward; and he 'forgot' what he was saying several times during the interview. His mood was depressed. Hallucinations, delusions, frank homicidal thoughts, and pre-occupation with violence were not present. There was no paranoid ideation or obsessive-compulsive thought."

NOTE: Additional examples would flesh out this description. This case is ONLY an example, NOT a model or standard. Alternatively, a checklist could be used to document the Single System Examination.

Example: In evaluating a patient with mental retardation, the physician must examine and comment on every area of the Single System Examination. Constitutional, orientation, memory, attention span and concentration, language, associations, mood and affect, speech, thought processes, abnormal thoughts, judgment and insight, fund of knowledge, and musculoskeletal need comment. “Ht- 4'8", wt- 110#, T- 98.4. The patient responded well to the examiner's questions and requests. He engaged in the interview to the best of his ability. He was neatly dressed. His ears appeared low set; he had wide-spaced eyes and a prominent forehead. His speech was understandable but articulation problems were present: *w* for *r*, dark *l* and voiceless *th*. His thought content was impoverished, but there was no hallucination, delusion, or suicidal, homicidal, or paranoid thought. Thought flow and associations were normal. The patient’s judgment was limited. He did not understand several age-appropriate questions and looked to his mother for help. He lacked insight into his delays. His gait was awkward and clumsy. His posture appeared rigid. Mother reported he was obsessed with buttons and he played repeatedly with them during the interview (compulsion). With support and prompts, he was able to recall 3 of 3 items immediately and after 5 minutes. He was oriented x3. His fund of knowledge was diminished. He could repeat 3 digits forward and 2 digits backward.”

NOTE: Additional examples would flesh out this description. This case is ONLY an example, NOT a model or standard. Alternatively, a checklist could be used to document the Single System Examination.

MEDICAL DECISION-MAKING

History
Examination
⇐⇐⇐**Medical Decision-Making**
Counseling and Coordination of Care
Nature of Presenting Problem
Time

The complexity of decision-making is one of the three key determinants of the level of E/M service. There are four levels of decision-making. Medical decision-making refers to the complexity of establishing a diagnosis and/or selecting a management option, as measured by:

- ✓ the number of possible diagnoses and/or the number of management options that must be considered;
- ✓ the amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed; and
- ✓ the risk of significant complications, morbidity and/or mortality, as well as comorbidities, associated with the patient's presenting problem(s), the diagnostic procedure(s) and/or the possible management options (AMA & CMS, 1997).

LEVELS OF DECISION-MAKING

Type of Decision-Making	**Number of Diagnoses or Management Options**	**Amount or Complexity of Data Reviewed**	**Risk of Complication, Morbidity, or Mortality**
Straight-Forward	Minimal	Minimal or none	Minimal
Low Complexity	Limited	Limited	Low
Moderate Complexity	Multiple	Moderate	Moderate
High Complexity	Extensive	Extensive	High

NUMBER OF DIAGNOSES OR MANAGEMENT OPTIONS

The number of possible diagnoses and/or the number of management options that must be considered is based on the number and types of problems addressed during the encounter, the complexity of establishing a diagnosis, and the management decisions that are made by the physician.

Generally, decision-making with respect to a diagnosed problem is easier than that for an identified but undiagnosed problem. The number and type of diagnostic tests employed may be an indicator of the number of possible diagnoses. Problems that are improving or resolving are less complex than those that are worsening or failing to change as expected. The need to seek advice from others is another indicator of complexity of diagnostic or management problems.

For each encounter, an assessment, clinical impression or diagnosis should be documented. It may be explicitly stated or implied in documented decisions regarding management plans and/or further evaluation.

For a presenting problem with an established diagnosis, the record should reflect whether the problem is:

- ✓ improved, well-controlled, resolving, or resolved;
- ✓ inadequately controlled, worsening, or failing to change as expected.

For a presenting problem without an established diagnosis, the assessment or clinical impression may be stated in the form of differential diagnoses or as a “possible,” “probable,” or “rule out” (R/O) diagnosis.

The initiation of, or changes in, treatment should be documented. Treatment includes a wide range of management options including patient instructions, nursing instructions, therapies, and medications.

If referrals are made, consultations requested, or advice sought, the record should indicate to whom or where the referral or consultation was made or from whom the advice was requested (AMA & CMS, 1997).

AMOUNT AND/OR COMPLEXITY OF DATA TO BE REVIEWED

The amount and complexity of data to be reviewed is based on the types of diagnostic testing ordered or reviewed. A decision to obtain and review old medical records and/or obtain history from sources other than the patient (e.g., school, parent, therapist, pediatrician), increases the amount and complexity of data to be reviewed.

Discussion of contradictory or unexpected test results with the physician who performed or interpreted the test is an indication of the complexity of data being reviewed. On occasion the physician who ordered a test may personally review the image, tracing, or specimen to supplement information from the physician who prepared the test report or interpretation; this is another indication of the complexity of data being reviewed.

If a diagnostic service (test or procedure) is ordered, planned, scheduled, or performed at the time of the E/M encounter, the type of service, e.g. rating scale, lab, or x-ray, should be documented.

The review of rating scales, lab, radiology, and/or other diagnostic tests should be documented. A simple notation such as “WBC elevated,” or “chest x-ray unremarkable,” is acceptable. Alternatively, the review may be documented by initialing and dating the report containing the test results.

A decision to obtain old records or additional history from the family, caregiver, or other source to supplement that obtained from the patient should be documented.

Relevant findings from the review of old records, and/or the receipt of additional history from the family, caregiver, or other source to supplement that obtained from the patient should be documented.

NOTE: Straightforward medical decision-making probably DOES NOT exist in child and adolescent psychiatry.

MEDICAL DECISION-MAKING OF LOW COMPLEXITY

Low complexity decision-making also may not exist in child and adolescent psychiatry. Example: mother states Johnny, age 7, stole a pack of gum and wants to know what to do. The physician makes NO further inquiries into Johnny's biopsychosocial functioning and tells her to have him return it to the store.

MEDICAL DECISION-MAKING OF MODERATE COMPLEXITY

While the physician does NOT need to document every option considered, he or she could state: "Decision-making was moderately complex and I considered medication (antidepressants or stimulants) and family therapy (Structural or Bowen). The child was already engaged in behavior management program for his ADHD. I added stimulant medication."

MEDICAL DECISION-MAKING OF HIGH COMPLEXITY

As above, but one could state "High complexity. I considered individual psychotherapy (cognitive or psychoanalytic), group therapy, pharmacology (serotonin reuptake inhibitor, tricyclic, or atypical) and school intervention, separately and in combination, to treat the depression." Unless the patient is severely psychotic, violent, homicidal, or suicidal, decision-making is unlikely to be of “high complexity.”

THE "HEAD" SYSTEM FOR DOCUMENTING E/M SERVICES

Karl Stevenson, M.D., has designed a variation of the **S** (subjective), **O** (objective), **A** (assessment), **P** (Plan) organization of record keeping for CPT. His system is identified by the acronym HEAD:

H (History)
E (Examination)
A (Assessment)
D (Decision-making)

Time______ (record number of minutes in service)

The Audit

Step 1. Describe History

History is described according to the parameters described in the table below.

HPI	Brief	Brief	Brief	Extended	Extended
ROS	None	None	Problem-Pertinent	Extended	Complete
PFSH	None	None	None	Pertinent	Complete
	Problem-Focused	Problem-Focused	Expanded Problem-Focused	Detailed	Comprehensive

The reviewer will circle:

- ✓ HPI type
- ✓ ROS - what is documented?
- ✓ PFSH - what is documented?

The reviewer then will draw a vertical line through the circles and read the history type below.

RULE: Value as far to left as possible. For example, if there is a "none" under ROS, that history is Problem-Focused or the lowest level, e.g. 99201 or 99211, etc., regardless of the HPI or PFSH entries. See end of step 4.

Example:

HPI	Brief	**Extended**	Extended
ROS	Problem-Pertinent	Extended	Complete
PFSH	None	**Pertinent**	Complete
	Expanded Problem-Focused	Detailed	Comprehensive

Step 2. Describe Examination

The reviewer will count the organ systems examined or elements examined from a Single System Examination (SSE) and determine whether the examination is:

- ✓ Problem-Focused (1-5 elements of the SSE)
- ✓ Expanded Problem-Focused (6+ elements)
- ✓ Detailed (6+elements with 2+sub-elements)
- ✓ Comprehensive (9+elements)

NOTE: "All other systems negative" counts for ALL OTHER SYSTEMS and qualifies for comprehensive examination. "Abnormal" counts for nothing unless the abnormality is described.

Step 3. Describe Assessment

A list of diagnoses is sufficient.

Step 4. Describe Medical Decision-Making

(A) The reviewer assigns points for the level of intensity of the first two of the three components of medical decision-making:

- ✓ Number of diagnoses or management options
- ✓ Amount/Complexity of data to be reviewed according to the following scoring system:

Diagnoses/problem categories

- ✓ 1 point for self-limited problems, e.g. insect bite, cold.
- ✓ 2 points for a single problem that is worsening, e.g. tics, increasing in number
- ✓ 3 points for a new problem
- ✓ 4 points for a new problem requiring additional work-up

Amount/Complexity of data to be reviewed

- ✓ 1 point for:
  - o review and order of lab tests
  - o review and order of radiological tests
  - o review and order of EEG, EKG, psychological testing, etc.
  - o discussion of tests with performing physician
  - o independent review of images
  - o decision to obtain old records
- ✓ 2 points for review and summary of old records, or obtaining history from collateral sources.

(B) Next, the reviewer determines risk of complication, morbidity, or mortality from the following Table of Risk.

TABLE OF RISK

Level of Risk	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
Minimal	✓ One self-limited or minor problem, e.g., cold, insect bite, tinea corporis	✓ Laboratory tests requiring venipuncture ✓ Chest x-rays ✓ EKG/EEG ✓ Urinalysis ✓ Ultrasound, e.g., echocardiography KOH prep	✓ Rest ✓ Gargles ✓ Elastic bandages ✓ Superficial dressings
Low	✓ Two or more self-limited or minor problems ✓ One stable chronic illness, e.g., well controlled hypertension, non-insulin dependent diabetes, cataract, BPH ✓ Acute uncomplicated illness or injury, e.g., cystitis, allergic rhinitis, simple sprain	✓ Physiologic tests not under stress, e.g., pulmonary function tests ✓ Non-cardiovascular imaging studies with contrast, e.g., barium enema ✓ Superficial needle biopsies ✓ Clinical laboratory tests requiring arterial puncture ✓ Skin biopsies	✓ Over-the-counter drugs ✓ Minor surgery with no identified risk factors ✓ Physical therapy ✓ Occupational therapy ✓ IV fluids without additives
Moderate	✓ One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment ✓ Two or more stable chronic illnesses ✓ Undiagnosed new problems with uncertain prognosis, e.g., lump in breast ✓ Acute illness with systemic symptoms, e.g., pyelonephritis, pneumonitis, colitis ✓ Acute complicated injury, e.g., head injury with brief loss of	✓ Physiologic tests under stress, e.g., cardiac stress test, fetal contraction stress test ✓ Diagnostic endoscopies with no identified risk factors ✓ Deep needle or incisional biopsy ✓ Cardiovascular imaging studies with contrast and no identified risk factors, e.g., arteriogram, cardiac catheterization ✓ Obtain fluid from body cavity, e.g. lumbar puncture,	✓ Minor surgery with identified risk factors Elective major surgery (open percutaneous or endoscopic) with no identified risk factors ✓ Prescription drug management ✓ Therapeutic nuclear medicine ✓ IV fluids with additives Closed treatment of fracture or dislocation without manipulation

	consciousness	thoracentesis,culdocen tesis	
High	✓ One or more chronic illnesses with severe exacerbation progression, or side effects of treatment ✓ Acute or chronic illnesses or injuries that pose a threat to life or bodily function, e.g., multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure ✓ An abrupt change in neurologic status, e.g., seizure, TIA, weakness, sensory loss	✓ Cardiovascular imaging studies with contrast with identified risk factors ✓ Cardiac electrophysiological tests ✓ Diagnostic Endoscopies with identified risk factors ✓ Discography	✓ Elective major surgery (open, percutaneous or endoscopic) with identified risk factors ✓ Emergency major surgery (open, percutaneous or endoscopic) ✓ Parenteral controlled substances ✓ Drug therapy requiring intensive monitoring for toxicity ✓ Decision not to resuscitate or de-escalate care because of poor prognosis ✓ Suicidal/homicidal ideation

(C) Finally, the reviewer determines level of complexity of decision-making using the following table.

Level of Complexity

Number of Diagnoses or Management Options	Data To Be Reviewed	Risk of Complication, Morbidity, Mortality	Type of Decision-Making
Minimal	Minimal or None	Minimal	Straight-Forward
Limited	Limited	Low	Low Complexity
Multiple	Moderate	Moderate	Moderate Complexity
Extensive	Extensive	High	High Complexity

(CPT, 2008, p.8)

CMS has indicated it will change the rule of valuing as far to the left as possible for decision-making. Its reviewers will be instructed to **value toward the right** as indicated by two of the three categories above (number of diagnostic/management options; data to be reviewed, risks). AACAP members should stay tuned and check the module updates for implementation dates for these possible changes.

Step 5. TIME: ____ (FILL IN THE NUMBER OF MINUTES INVOLVED)

COUNSELING AND COORDINATION OF CARE

History
Examination
Medical Decision-Making
⇐⇐⇐Counseling and Coordination of Care
Nature of Presenting Problem
Time

Add up the total time spent in interpretation/coordination of care and/or patient counseling.
COUNSELING/COORDINATION TOTAL TIME: _________

Example: "I discussed with staff the medication side effects, mother's resistance to psychological intervention...." etc.

IF COUNSELING AND COORDINATION OF CARE IS GREATER THAN 50% OF TOTAL TIME, TOTAL TIME DETERMINES THE APPROPRIATE CPT CODE. (CPT, 2007, p. 8)

PATIENT DEFINITIONS AND RELATED SPECIFIC CODES

This section describes commonly used CPT codes in the major service categories used by child and adolescent psychiatrists. The reader is referred to the Physicians' Current Procedural Terminology (CPT, 2007) for further information on these codes and their use.

The categories of codes covered in this section include:

- ✓ Evaluation and management codes
- ✓ Psychiatric diagnostic codes
- ✓ Psychotherapy codes
- ✓ Care plan oversight codes
- ✓ Hospital observation services codes
- ✓ Modifier codes and their appropriate uses.
- ✓ Physician standby services codes
- ✓ Polysomnography codes
- ✓ Prolonged services codes

EVALUATION AND MANAGEMENT CODES

OUTPATIENT

New Patient (not seen by you or office-mate in your specialty in past three years)

99201 (10 minutes)
Problem focused history
Problem focused examination
Straightforward medical decision-making

99202 (20 minutes)
An expanded problem focused history
Expanded problem focused examination
Straightforward medical decision-making

99203 (30 minutes)
A detailed history
A detailed examination
Medical decision-making of low complexity

99204 (45 minutes)
A comprehensive history
A comprehensive examination
Medical decision-making of moderate complexity

99205 (60 minutes)
A comprehensive history
A comprehensive examination

Medical decision-making of high complexity

(For prolonged services, see separate section below.)

Established Patient (seen within past three years)
Two of three components (history, examination, medical decision-making) determine the level of service.

99211 (5 minutes, may or may not require a physician)

99212 (10 minutes)
A problem focused history
A problem focused examination
Straight forward decision-making

99213 (15 minutes)
An expanded problem focused history
An expanded problem focused examination
Medical decision-making of low complexity

99214 (25 minutes)
A detailed history
A detailed history
Medical decision-making of moderate complexity

99215 (40 minutes)
A comprehensive history
A comprehensive examination
Medical decision-making of high complexity

HOSPITAL INPATIENT
(Includes partial hospital patient - CPT 2008, p. 12)
Initial Care -- new or established patient

99221 (30 minutes)
A comprehensive history
A comprehensive examination
Straight forward medical decision-making

99222 (50 minutes)
A comprehensive history
A comprehensive examination
Medical decision-making of moderate complexity

99223 (70 minutes)
A comprehensive history

A comprehensive examination
Medical decision-making of high complexity

(For prolonged services, see separate section below.)

Subsequent Care
Two of three components (history, examination, decision-making) determine the level of service.

99231 (15 minutes)
A problem focused interval history
A problem focused examination
Medical decision-making that is straightforward or of low complexity

99232 (25 minutes)
An expanded problem focused interval history
An expanded problem focused examination
Medical decision-making of moderate complexity

99233 (35 minutes)
A detailed interval history
A detailed examination
Medical decision-making of high complexity

NURSING FACILITY/RESIDENTIAL TREATMENT CENTER
Initial Consultation -- New or Established Patient

99304 (25 minutes)
A detailed interval history
A comprehensive examination
Straight forward medical decision-making

99305 (35 minutes)
A detailed interval history
A comprehensive examination
Medical decision-making of moderate complexity

99306 (45 minutes)
A comprehensive history
A comprehensive examination
Medical decision-making of high complexity

Subsequent Care
99307 (10 minutes)
A problem focused interval history
A problem focused examination

Straightforward medical decision making

99308 (15 minutes)
An expanded problem focused interval history
An expanded problem focused examination
Medical decision-making of low complexity

99309 (25 minutes)
A detailed problem focused interval history
A detailed problem focused examination
Medical decision-making of moderate complexity

99310 (35 minutes)
A comprehensive interval history
A comprehensive examination
Medical decision-making of high complexity

CONSULTATIONS
All reports must include a heading "requested by __________" and must conclude with "recommendations."

Changes in Consultation Coding in 2009

This section is current as of the date of this revision (9/20/09) but could change at any time as CMS has a proposal under consideration that would eliminate all of the consultation codes.

A consultation is defined as a "type of service provided by a physician whose opinion or advice regarding an evaluation and/or management of a specific problem is requested by another physician or appropriate source." The consultant should have more expertise in the specific problem or situation than the requesting provider.

The Office of Inspector General (OIG) report from March 2006, reviewed 400 claims made in 2001 and found that 75% of services did not meet all program requirements. The OIG estimated $1.1 billion in 2001 of improper payments and recommended physician education by CMS.

Type of Improper Payment	Percent of Services
Not a Consultation	19
Incorrect Type	2
Upcoded	41
Downcoded	5
Undocumented	9
Total	75

There are two types of consultations: outpatient for service in an office or other ambulatory facility using codes 99241-99245, and inpatient for service in an inpatient hospital, nursing facility, or partial hospital using codes 99251-99255.

Confirmatory consultation codes and follow-up consultation codes have been discontinued. Confirmatory consultations may be reported using a consultation code when the consultation requirements (below) are met. Other confirmatory consultations and follow-up visits may be billed with the appropriate non-consultation code.

Consultation Requirements

Prior to the consultation, there is a request from a health care professional for the opinion or advice for the evaluation and/or management of specific problem. The request and reason for consultation must be documented in the charts of the requestor and the consultant. After the consultation, the consultant provides the referrer with a written report of findings and recommendations. The report may be placed in the chart when the chart shared

The intent needs to be for opinion or advice. The request needs to be not only documented but possible to be acted upon. For example, an ER physician sending a patient to an outpatient provider and a psychologist requesting a medication evaluation are transfers of care, not consultations, as the requesting providers are not in positions to act on the advice.

Example situations:

Situation 1
The originating physician is unsure of how to treat and requests someone with expertise (the performing physician) for advice. The patient returns to the originating physician and the performing physician may be a consultation.

Situation 2
The originating physician knows the patient has a problem and that he or she is not the best person to treat the problem. The originating physician asks an expert to treat the patient for the particular problem. This is a transfer of care and may not be billed as a consultation

Situation 3
The originating physician asks the expert for advice. The expert evaluates the patient and then assumes care for the problem in question. This is a consultation followed by treatment.

Special situations
Second opinions initiated by a health care provider may be billed as consultation. Second opinions initiated by the patient or a family member are NOT consultations, but may be billed with a different E/M code. Second opinions that are MANDATED (e.g., by third party payer or hospital) are NOT covered by Medicare, but may possibly be billed to the mandating entity. Modifer -32 should be used.

Consults requested by a professional in the same group and the same specialty must include documentation that the consulting professional has expertise in a specific medical area beyond the requesting professional's knowledge. A supervisor may not be asked for consultation. For inpatient hospital, nursing facility, and partial hospital, each physician may only report a consult

code once per stay, even if a new problem develops. For this purpose, physicians of the same specialty AND group are considered the same physician. For outpatient, a consult code may be billed each time a new consultation is requested for the same or different problem even by the same requestor.

References:
Office of Inspector General http://www.oig.hhs.gov/oei/reports/oei-09-02-00030.pdf;
Centers for Medicare and Medicaid Services
http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4215.pdf
http://www.cms.hhs.gov/transmittals/downloads/R788CP.pdf

In Office -- New or Established Patient

99241 (15 minutes)
A problem focused history
A problem focused examination
Straight forward medical decision-making

99242 (30 minutes)
An expanded problem focused history
An expanded problem focused examination
Straight forward medical decision-making

99243 (40 minutes)
A detailed history
A detailed examination
Medical decision-making of low complexity

99244 (60 minutes)
A comprehensive history
A comprehensive examination
Medical examination making of moderate complexity

99245 (80 minutes)
A comprehensive history
A comprehensive examination
Medical decision-making of high complexity

(For prolonged services, see separate section below.)

Initial Inpatient Consultation -- New or Established Patient

99251 (20 minutes)
A problem focused history
A problem focused examination
Straight forward medical decision-making

99252 (40 minutes)
An expanded problem focused history
An expanded problem focused examination
Straight forward medical decision-making

99253 (55 minutes)
A detailed history
A detailed examination
Medical decision-making of low complexity

99254 (80 minutes)
A comprehensive history
A comprehensive examination
Medical examination making of moderate complexity

99255 (110 minutes)
A comprehensive history
A comprehensive examination
Medical decision-making of high complexity

(For prolonged services, see separate section below.)

PSYCHIATRIC DIAGNOSTIC/EVALUATIVE INTERVIEW CODES

NOTE: Documentation standards are being developed for these codes.

90801 Psychiatric diagnostic interview examination including history, mental status or disposition. This code may include communication with the family and other sources and ordering and medical interpretation of laboratory or other medical diagnostic studies.

90802 Interactive medical psychiatric diagnostic interview examination.

Psychological Diagnostic Testing Procedures

96101 Psychological testing by psychologist or physician
96102 Psychological testing by technician
96103 Psychological testing administered by computer
96105 Assessment of aphasia
96110 Developmental testing, limited
96111 Developmental testing, extended
96116 Neurobehavioral status exam
96118 Neuropsychological testing by psychologist or physician
96119 Neuropsychological testing by technician
96120 Neuropsychological testing administered with computer

PSYCHOTHERAPY CODES

The individual psychotherapy codes listed below (90841-44, 90855) may still be honored by a few third party payers, but have not existed in CPT since 1997.

1. 90841: time unspecified
2. 90842: 75-80 minutes
3. 90843: 20-30 minutes
4. 90844: 45-50 minutes
5. 90855: Interactive individual medical psychotherapy - uses interaction beyond words, i.e. art, play during the therapy

For Medicare billing, however, use only the following codes that bundle psychotherapy and E/M services (below).

Bundled E/M - Psychotherapy Codes

As a result of administrative pressures, CMS introduced bundled codes in the November, 1996 Final Rule (Department of Health & Human Services, 1996).

- ✓ They replaced the five codes listed above for Medicare patients effective January 1, 1997.
- ✓ Other insurance companies are adopting the bundled codes. If a claim is electronically submitted to Medicare, Medicare will crosswalk that claim and submit it to any Medigap secondary insurance. The provider will have to submit that claim if filing is not done electronically with Medicare.
- ✓ The bundled codes reflect the greater physician work documented in the five-year review process completed by the Relative-Value Update Committee (RUC) in 1996.
- ✓ The bundled codes are based on:
    1. Site of service (office vs. inpatient, partial, residential facility)
    2. Face-to-face time with patient
    3. Type of therapy: insight, supportive, cognitive behavioral vs. interactive
    4. Presence or absence of medical evaluation and management services (billed only by primary care providers - M.D., D.O., R.N., Physician Assistant).
- ✓ Facility-based patients require less provider work (due to the support staff available at the facility) and are reimbursed slightly less than outpatient or office patient visits.
- ✓ More face-to-face time requires more work.
- ✓ Interactive (play) therapy requires more work than other therapies.
- ✓ Additional medical evaluation and management requires more work and reimburses more.

OFFICE, INDIVIDUAL PSYCHOTHERAPY CODES				
Code	**Time (Minutes)**	**E/M**	**Physician Work**	**Total RVU**
90804	20-30	NONE	1.21	1.77
90805	20-30	YES*	1.37	1.97
90806	45-50	NONE	1.86	2.47
90807	45-50	YES*	2.02	2.77
90808	75-80	NONE	2.79	3.63
90809	75-80	YES*	2.95	3.92

*Presence of E/M requires additional time and documentation. It cannot be "worked into" the face-to-face therapy time. Time must be **added** to the minimal face-to-face therapy time.

OFFICE, INTERACTIVE PSYCHOTHERAPY CODES				
Code	**Time (Minutes)**	**E/M**	**Physician Work**	**Total RVU**
90810	20-30	NO	1.32	1.88
90811	20-30	YES*	1.48	2.19
90812	45-50	NO	1.97	2.69
90813	45-50	YES*	2.13	2.99
90814	75-80	NO	2.90	3.66
90815	75-80	YES*	3.06	4.14

*Presence of E/M requires additional time and documentation. It cannot be "worked into" the face-to-face therapy time. Time must be **added** to the minimal face-to-face therapy time.

FACILITY, INDIVIDUAL PSYCHOTHERAPY CODES				
Code	**Time (Minutes)**	**E/M**	**Physician Work**	**Total RVU**
90816	20-30	None	1.25	1.64
90817	20-30	YES*	1.41	1.82
90818	45-50	NONE	1.89	2.44
90819	45-50	YES*	2.05	2.62
90821	75-80	NONE	2.83	3.60
90822	75-80	YES*	2.99	3.79

*Presence of E/M requires additional time and documentation. It cannot be "worked into" the face-to-face therapy time. Time must be **added** to the minimal face-to-face therapy time.

FACILITY, INTERACTIVE PSYCHOTHERAPY CODES				
Code	**Time (Minutes)**	**E/M**	**Physician Work**	**Total RVU**
90823	20-30	NONE	1.36	1.77
90824	20-30	YES*	1.52	1.97
90826	45-50	NONE	2.01	2.59
90827	45-50	YES*	2.16	2.75
90828	75-80	NONE	2.94	3.74
90829	75-80	YES*	3.10	3.91

*Presence of E/M requires additional time and documentation. It cannot be "worked into" the face-to-face therapy time. Time must be **added** to the minimal face-to-face therapy time.

To obtain actual Medicare reimbursement for any procedure, multiply Total RVU by Conversion Factor (37.87). Example: For 90805, 1.97x 37.87 = $74.60 or for 90807, 2.77 x 37.87 = $104.90.

If the therapist is a physician or licensed prescriber in their state (M.D., D.O., R.N., or P.A.), that person may use either the psychotherapy codes or the bundled psychotherapy codes with E/M and bill the appropriate code above. That provider must document the E/M service provided. Possible examples include:

- ✓ Medical diagnostic evaluation including comorbid medical diagnoses
- ✓ Drug management
- ✓ Physician orders
- ✓ Interpretation of laboratory or medical diagnostic tests
- ✓ Physical examination.

The bundled codes were surveyed by AACAP, the American Psychiatric Association, the American Psychological Association, the National Association of Social Workers, and the American Nurses Association for RVUs, and the RUC accepted the survey recommendations.

Additional Psychotherapy Codes

PSYCHOANALYSIS				
Code	**Time (Minutes)**	**E/M**	**Physician Work**	**Total RVU**
90845	unspecified	NONE	1.79	2.27

FAMILY THERAPY CODES				
Code	**Time (Minutes)**	**E/M**	**Physician Work**	**Total RVU**
90846 – without patient	unspecified	NONE	1.83	2.42
90847 - with patient	unspecified	NONE	2.21	3.01
90849 – multiple family	unspecified	NONE	0.59	0.91

GROUP THERAPY CODES				
Code	**Time (Minutes)**	**E/M**	**Physician Work**	**Total RVU**
90853	unspecified	NONE	0.59	0.86
90857 - interactive	unspecified	NONE	0.63	0.97

Other Psychiatric Services/ Procedures Codes

Code	**Time (Minutes)**	**Physician Work**	**Total RVU**
90862 – Medication management	unspecified	0.95	1.53
90865 – Narcosynthesis	unspecified	2.84	4.29

90870 – ECT	unspecified	1.88	3.79
90875 – Psychophysiological therapy	20-30 min	1.20	1.97
90876 – Psychophysiological therapy	45-50 min	1.90	2.91
90880 – Hypnotherapy	unspecified	2.19	2.94
90882 – Environmental manipulation	unspecified	0.00	0.00
90885 – Psy evaluation of records	unspecified	0.97	1.33
90887 – Interpretation with family	unspecified	1.48	2.32
90889 – Preparation of report	unspecified	0.00	0.00
90899 – Unlisted psychiatric service	unspecified	0.00	0.00

Having an established RVU does not guarantee reimbursement by the insurance carriers. You must check with each carrier to establish reimbursement policies. If these are listed as a non-covered service under the plan, you may bill the patient directly for the service.

CARE PLAN OVERSIGHT CODES

99374 - used for 15 to 29 minutes per month of physician supervision of patients under the care of **home health agencies**, who require complex treatment and regular physician attention to care plans, review of patient status reports and tests, communication with other health care professionals, and integration of new information into the medical treatment plan and/or adjustment of medical therapy.

99375 - used for services beyond 30 minutes. The time is cumulative delivered over a 30 day period.

99377 - used to 15 to 29 minutes for a **hospice** care patient.

99378 - used for services beyond 30 minutes.

99379 - for 15 to 29 minutes for a **nursing facility** patient.

99380 - is used for services beyond 30 minutes.

HOSPITAL OBSERVATION SERVICES CODES

99217 - added for observation care discharge day management, and it may be used to report services on any day other than the day of admission. Services include final examination, discussion of the hospital stay, instruction of continuing care, and preparation of discharge records.

99218 - used for initial observation care, per day, for the evaluation and management of a patient who requires a detailed or comprehensive examination; and medical decision-making that is straightforward or of low complexity. Usually the problem(s) requiring admission to "observation status" are of low severity.

99219 - used for initial observation care, per day, when the medical decision-making id of moderate complexity. Usually the problem(s) requiring admission are of high severity.

99220 - used for initial observation care, per day when the medical decision-making is of high complexity. Usually the problem(s) requiring admission are of high severity.

99238 - hospital discharge management, has been retained and modified to exclude the observation portion.

MODIFIER CODES

Modifier codes are used to document a procedure or service that has been altered in some way due to a specific circumstance, however its definition or code has not been charged.

Specific Modifier Codes

-21 Prolonged E/M Service
This modifier was deleted for the 2009 CPT. To report prolonged physician services, use 99354-99357 (see Prolonged Services on page 45).

-22 Unusual Procedural Services
When the service(s) provided is greater than that usually required for the listed procedure, it may be identified by adding modifier '-22' to the usual procedure number. A report may also be appropriate. Documentation must support the substantial additional work and the reason for the additional work. This modifier should not be appended to an E/M service.

-25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Day of a Procedure
The physician may need to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the usual pre-procedure and post procedure care associated with the procedure that was performed. This circumstance may be reported by adding the modifier '-25' to the appropriate level of E/M service.

-32 Mandated Services
Services related to mandated consultation and/or related services (e.g., PRO, third party payer) may be identified by adding the modifier '-32' to the basic procedure.

-51 Multiple Procedures
When multiple procedures are performed on the same day or at the same session, the major procedure or service may be reported as listed. The secondary additional, or lesser procedure(s) or service(s) may be identified by adding the

modifier '-51' to the secondary procedure or service code(s). This modifier may be used to report multiple medical procedures performed at the same session, as well as a combination of medical and surgical procedures, or several surgical procedure performed at the same operative session.

-52 Reduced Services
At times the clinician may elect to partially reduce or eliminate parts of a procedure. Use the modifier -52 to report the reduced service.

-90 Reference (Outside) Laboratory
When laboratory procedures are performed by a party other than the treating or reporting physician, the procedure may be identified by adding the modifier '-90' to the usual procedure number or by use of the separate five digit modifier code 09990.

-99 Multiple Modifiers
Under certain circumstances two or more modifiers may be necessary to completely delineate a service. In such situations modifier '-99' should be added to the basic procedure, and other applicable modifiers may be listed as part of the description of the service. Modifiers code 09999 may be used as an alternative to modifier '-99'.

PHYSICIAN STAND-BY SERVICES

99360 - used to report each 30 minutes of physician standby services requested by another physician. It involves prolonged attendance without face to face contact, but the physician may not provide care to other patients during this time.

POLYSOMNOGRAPHY

These codes cover the continuous monitoring of various physiological and pathophysiological parameters of sleep for six or more hours, including review, interpretation and report. This monitoring is used to diagnose a variety of sleep disorders and evaluate patient response to therapies such as nasal continuous positive airway pressure (CPAP). For a study to be coded as polysomnography, sleep must be recorded and staged.

95805 – Multiple Sleep Latency test
95806 - Sleep Study, unattended
95807 - Sleep Study attended
95808 - Polysomnography, 1-3 parameters
95810 - Polysomnography, 4 or more parameters
95811 - Polysomnography with CPAP

PROLONGED SERVICES CODES

With Face-To-Face Contact

New CPT codes for prolonged, face-to-face services have been instituted to replace 99150 and 99151, which have been deleted.

The code series 99354-99357 should be used when a physician provides direct patient contact greater than 30 minutes beyond the usual service. Each of these codes may be reported in addition to other physician services, including evaluation and management services. The series enables physicians to report the total duration of face to face time on a given date, even if the time spent is not continuous. (Use -22 modifier for 0-29 minutes beyond usual service.)

99354 - used for the first hour of prolonged OUTPATIENT service on a given date. This code may also be used to report a total duration of prolonged service of 30-60 minutes on a give date. The code may be used only once per date.

99355 - used to report each additional 30 minutes of OUTPATIENT services beyond the first hour. The code may also be used to report the final 15 to 30 minutes of prolonged service on a given date.

99356 - used for the first hour of prolonged INPATIENT service on a given date. This code may also be used to report a total duration of prolonged service of 30-60 minutes on a give date. The code may be used only once per date.

99357 - used to report each additional 30 minutes of INPATIENT services beyond the first hour. The code may also be used to report the final 15 to 30 minutes of prolonged service on a given date.

Without Face-To-Face Contact
Codes 99358 AND 99259 are used when a physician provides prolonged services that **do not involve face to face contact**, and can only be used when another physician service has been provided, including evaluation and management codes.

99358 - used for the first 30 to 60 minutes of prolonged evaluation and management before and/or after face to face patient contact. Services might include review of extensive records and tests, communication with other professionals, or communication with the family.

99359 - used for each additional 30 minutes.

TEAM CONFERENCES

99366 Medical Team Conference, Direct (Face-to-Face) Contact With Patient and/or Family

30 minutes or more
Participation by non-physician, qualified health care professional
Physicians report with Evaluation Management codes, NOT 99366

Medical Team Conference, Without Direct (Face-to-Face) Contact with Patient and/or Family
99367 30 minutes or more
Physicians use 99367
99368 30 minutes or more
Non-physician, qualified health care professionals use 99368

TELEPHONE CALLS

These are non face-to-face services initiated by an established patient or guardian of an established patient. If the physician sees the patient within 24 hours of the phone call, the code is NOT reported, but is considered part of the pre-service work.

99441 call is not originating from a related E/M visit within the past 7 days and does not lead to an E/M service or procedure within the next 24 hours. 5 – 10 minutes of medical discussion
99442 11 – 20 minutes of medical discussion
99443 21 – 30 minutes of medical discussion

On-line Medical Evaluation

99444 A reportable service includes all the communication – related telephone calls, prescription provision, laboratory orders – pertaining to the on-line encounter. The 7 day pre and 24 hour post rules (see Telephone Calls above) apply.

OTHER SECTIONS OF THE CPT MANUAL

Any physician may utilize, as appropriate, any code from the CPT manual to describe services provided. In particular, child and adolescent psychiatrists may want to review the neurology, consultation, emergency department, domiciliary, preventive medicine and miscellaneous services of the manual for procedures that they may be providing but not currently coding, and therefore not being reimbursed. Child and adolescent psychiatrists may want to pay particular attention to the codes that follow.

Home visit codes – 99341 - 99350
Preventive counseling - 99401-4
Group preventive counseling - 99411-2

REFERENCES

American Medical Association (2009), *Current Procedural Terminology (CPT), Professional Edition*

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American Medical Association (1997), Revised Documentation Guidelines for Evaluation and Management Services. *CPT Assistant* 7: 1-24

Department of Health & Human Services (1996), 42CFR Parts 410 and 415:Medicare Program: Revisions to Payment Policies and Five-Year Review of and Adjustments to the Relative Value Units Under the Physician Fee Schedule for calendar Year 1997. *Federal Register* 61:59490-59724

Hakim D (2005), Iacocca, away from the grind, still has a lot to say. *NY Times*, July 19, 2005:C1)

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NOTE
Many of these publications can be ordered from AMA at
1-800-621-8335
http://www.ama-assn.org

PARTIAL GLOSSARY

HEALTH CARE FINANCING ADMINISTRATION (HCFA) A component of the U.S. Department of Health and Human Services that administers the Medicare program and certain aspects of state Medicaid programs. Renamed **CMS** (Center for Medicare-Medicaid Services) after June, 2001.

PHYSICIAN CURRENT PROCEDURAL TERMINOLOGY (CPT) "…a list of descriptive terms and identifying codes for reporting medical services and procedures that physicians perform. The purpose of CPT is to provide a uniform language that accurately describes medical, surgical, and diagnostic services, thereby serving as an effective means for reliable nationwide communication among physicians, patients, and third parties" (AMA, 1992).

PHYSICIAN PAYMENT REVIEW COMMISSION (PPRC). A federal advisory body created in 1986 by Congress to design reasonable and rational payments to physicians by Medicare. After three years of study and consultation, the commission recommended that the work of William Hsiao and his colleagues at Harvard University in developing the resource-based relative-value scale be adopted as the method used to revamp the Medicare fee schedule.

RELATIVE-VALUE UPDATE COMMITTEE (RUC) Formed in 1991 to make recommendations to CMS (HCFA) on the relative values to be assigned to new or revised codes in the CPT. It is composed of 28 members; an AACAP member served from 1996-1999 in the non-internal medicine rotating seat. In 1999, the RUC established the **PEAC** (Practice Expense Advisory Committee) to recommend Practice Expense (PE) Relative Value Units (RVU) for each CPT code to the RUC.

RELATIVE VALUE UNIT (RVU) A unit of measure designed to permit comparison of the amounts of resources required to perform various provider services by assigning weight to such factors as personnel time, level of skill, and sophistication of equipment required to render service.

RESOURCE-BASED RELATIVE VALUE (RBRV) The actual figure or value arrived at in relative, nonmonetary work units (relative value units) that can later be converted into dollar amounts as a means for determining reimbursement for provider (such as physicians and hospital) services. The formula for RBRV for a given service is: RBRV=(TW) (1+RPC) (1+AST), in which TW represents total work input by the provider; PRC is an index of relative specially practice cost; and AST is an index of amortized value for the opportunity cost of specialized training. Total work input is defined by four attributes: tine, mental effort and judgment, technical skill and physical effort, and psychological stress.

RESOURCE-BASED RELATIVE-VALUE SCALE (RBRVS) A method of reimbursement under Medicare that attempts to base physician reimbursement on the amount of resources, including cognitive and evaluative skills, required to diagnose and treat conditions. The approach weights what resources, such as practice costs and the cost of specialty training, have gone into the "manufacture" of a service or procedure. Since the 1930's physicians have been paid

according to the "customary, prevailing and reasonable" fee for a region of the country, and fee schedules reimbursed disproportionately for procedural services.

FOR MORE INFORMATION:

O'Leary, M (1994). *Lexicon: Dictionary of Health Care Terms, Organizations, and Acronyms for the Era of Reform*. Oakbrook Terrace, IL: Joint Commission on Accreditation of Healthcare Organizations.