Calculating E&M codes & 2018 Medicare Physician Fee Schedule Proposed Rule

Grace Wilson, RHIA
Objectives

- 2018 Medicare Physician Fee Schedule
- E/M Coding Overview
- Documentation Examples
- Proposed Documentation Changes
- Future of Coding
2018 Medicare Physician Fee Schedule

- Proposal includes updates to payment policies, payment rates, and quality provisions for services furnished under the Medicare PFS
- An effort to create a healthcare system that results in better accessibility, quality, affordability, empowerment, and innovation
- Identifies potentially misvalued codes, adds procedures to the telehealth list, and finalizes a number of new policies
Proposed Rule

- Proposed Policy, Payment, and Quality Provisions Changes to the Medicare Physician Fee Schedule for Calendar Year 2018
- Published July 13, 2017
- Public comment until September 11, 2017
- Final Rule display date November 2, 2017;
- Published date- Nov. 15, 2017
Summary of Major Provisions

- Potentially Misvalued Codes.
- Telehealth Services.
- Establishing Values for New, Revised, and Misvalued Codes.
- Establishing Payment Rates under the PFS for Nonexcepted Items and Services Furnished by Nonexcepted Off-Campus Provider-Based Departments of a Hospital.
- Evaluation & Management (E/M) Guidelines and Care Management Services.
- Care Coordination Services and Payment for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs).
- Payment for DME Infusion Drugs.
- Solicitation of Public Comments on Initial Data Collection and Reporting Periods for Clinical Laboratory Fee Schedule.
- Solicitation of Public Comments on Payment for Biosimilar Biological Products under Section 1847A of the Act.
Summary of Major Provisions Cont’d…

- Appropriate Use Criteria for Advanced Diagnostic Imaging Services.
- Medicare EHR Incentive Program.
- Medicare Shared Savings Program.
- Value-Based Payment Modifier and the Physician Feedback Program.
- MACRA Patient Relationship Categories and Codes.
- Medicare Diabetes Prevention Program.
“We agree with continued feedback from stakeholders that these guidelines are potentially outdated and need to be revised, especially the history and exam components”

- CMS acknowledgement that the current E/M guidelines create an administrative burden and increased audit risk for providers.
- Solution: CMS plans to carry out a multi-year effort to revise the current E/M documentation guidelines.
- Focus is on revising History and Exam E/M components with more emphasis on Medical Decision Making and/or time.
What are E&M Codes?

- E&M codes are ‘visit codes’.
- They represent the level of service provided by the provider or clinician.
- The code must be supported by provider documentation.
Codes are used for:

- Workload allocation
- Quality improvement
- Research and education
- Facility planning
- Billing and reimbursement
Provider Documentation Guidance

- Determine if the patient is new or established
- Document the history and objective data relevant to presenting problems
- Document what is clinically being performed and ordered for your patient
- Follow Attending and Resident supervision responsibilities
- Assign the correct diagnosis and procedure code based on the documentation
New Patient

- Patient that has not been seen in the facility within the past 3 years
- Patient that has been seen within the past 3 years but are new to the specialty
- Attending and Resident Documentation Responsibility – requires documentation of being seen by or discussed with the attending physician. A simple co-signature is not sufficient.
Components of Evaluation and Management (E&M) Codes

- History
- Exam
- Medical Decision Making
History

- Chief Complaint (CC) History of Present Illness (HPI)
- Past Medical, Family, Social History (PFSH)
- Review of Systems (ROS)
Chief Complaint (CC)

- “What is the reason for your visit today”
- Response “I feel fine” or “to refill prescription” or “Dr. X asked me to see you” or “for follow-up” are not a chief complaint
- Review prior note and problem list : “I see you were having migraines last time I saw you. Are these still happening?”
History of Present Illness (HPI)

- A historical description of the patient’s signs and symptoms of the chief complaint or chronic illnesses.

- Elements of HPI-
  - Location
  - Quality
  - Severity
  - Duration
  - Timing
  - Context
  - Associated signs and symptoms
  - Modifying factors
Past, Family, Social History (PFSH)

- **Past Medical:** describes the patient’s past medical/surgical history
- **Family:** Medical history of related family members
- **Social:** Factors that affect health such as smoking, alcohol consumption and recent stressors like unemployment or divorce.
Review of Systems Elements

- Constitutional
- Eyes
- ENT/ Mouth
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary

- Neurological
- Psychiatric
- Endocrine
- Hem/Lymph
- Allergy/Immune
The lack of ROS in the documentation will limit the history portion of the E&M calculation to a level 2 established patient code and a level 1 new patient code.

Reviewing and documenting 1 or 2 systems makes a big difference, documenting allergies = 1

Example of acceptable
- “The patient denies shortness of breath and all other systems were negative”

Unacceptable
- “All systems negative”
Physical Exam-1995 Guidelines

- **Body Areas**
  1) Head, including the face
  2) Neck
  3) Chest, including breasts and axillae
  4) Abdomen
  5) Genitalia, groin, buttocks
  6) Back, including spine
  7) Each extremity

- **Organ Systems**
  1) Constitutional (e.g., vital signs, general appearance)
  2) Eyes
  3) Ears, nose, mouth and throat
  4) Cardiovascular
  5) Respiratory
  6) Gastrointestinal
  7) Genitourinary
  8) Musculoskeletal
  9) Skin
  10) Neurologic
  11) Psychiatric
  12) Hematologic/lymphatic/immunologic
1997 Physical Exam Guidelines

- Cardiovascular
- Ear, Nose and Throat
- Eye
- Genitourinary (Male), (Female)
- Hematologic/Lymphatic/Immunologic
- Musculoskeletal
- Neurologic
- Psychiatric
- Respiratory
- Skin
Psychiatry Specialty Exam

SPECIALTY EXAM: PSYCHIATRY

Refer to data section (table below) in order to quantify. After reviewing the medical record documentation, identify the level of examination. Circle the level of examination within the appropriate grid in Section 5 (Page 3).

<table>
<thead>
<tr>
<th>Performed and Documented</th>
<th>Level of Exam</th>
</tr>
</thead>
<tbody>
<tr>
<td>One to five bullets</td>
<td>Problem Focused</td>
</tr>
<tr>
<td>Six to eight bullets</td>
<td>Expanded Problem Focused</td>
</tr>
<tr>
<td>At least nine bullets</td>
<td>Detailed</td>
</tr>
<tr>
<td>At least one bullet in the unshaded border AND every bullet in each box with the shaded borders</td>
<td>Comprehensive</td>
</tr>
</tbody>
</table>

(Circle the bullets that are documented.)

NOTE: For the descriptions of the elements of examination containing the words "and", "and/or", only one (1) of those elements must be documented.

<table>
<thead>
<tr>
<th>System/Body Area</th>
<th>Elements of Examination</th>
</tr>
</thead>
</table>
| 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 |

<table>
<thead>
<tr>
<th>System/Body Area</th>
<th>Elements of Examination</th>
</tr>
</thead>
</table>
| 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) |
| Psychiatric      | • Description of speech including: rate, volume, articulation, coherence, and spontaneity with notation of abnormalities (e.g., perseveration, paucity of language)  
                   • Description of thought processes including: rate of thoughts, content of thoughts (e.g., logical vs. illogical, tangential), abstract reasoning, and loosening  
                   • Description of associations (e.g., loose, tangential, circumstantial, intact)  
                   • Description of abnormal psychotic thoughts including: hallucinations, delusions, preoccupation with violence, homicidal or suicidal ideation, and obsessions  
                   • Description of the patient's judgment (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) |

(Enter the number of circled bullets in the boxes below. Then circle the appropriate level of care.)

<table>
<thead>
<tr>
<th>EXAM</th>
<th>One to Five Bullets</th>
<th>Six to Eight Bullets</th>
<th>At Least Nine Bullets</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level of Exam</td>
<td>Problem Focused</td>
<td>Expanded Problem Focused</td>
<td>Detailed</td>
</tr>
<tr>
<td>Comprehensive</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: All other body systems not defined on this form are not considered integral parts of a Psychiatric exam.
1995 Exam

- 1 system = Problem focused = 99212/99201
- 2-4 systems = Expanded PF = 99213/99202
- 5-7 systems = Detailed = 99214/99203
- 8+ systems = Comprehensive = 99215/99204,5

1997 Exam

- 1-5 bullets = Problem Focused
- 6-8 bullets = Expanded Problem Focused
- At least 9 bullets = Detailed
- At least one bullet in the box in the musculoskeletal box and every bullet in each box in constitutional and Psychiatric (for a Psych exam)
Medical Decision Making (MDM)

3 Parts
1. Diagnosis/management options
2. Amount of Data to be reviewed
3. Risk to patient
   - Every note depends heavily on the complexity of medical decision making.
     - Documentation of diseases and their interrelations with labs, x-rays, and the treatment plan builds the complexity of the encounter.
## Diagnosis/management options

<table>
<thead>
<tr>
<th>Problem Categories</th>
<th>Number X</th>
<th>Points =</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-limited, minor</td>
<td>(Max = 2)</td>
<td>1</td>
</tr>
<tr>
<td>Est. problem; stable, improved</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Est. problem; worsening</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>New problem (<em>to patient and/or examiner</em>), no additional workup</td>
<td>(Max = 1)</td>
<td>3</td>
</tr>
<tr>
<td>New problem (<em>to patient and/or examiner</em>), additional workup planned</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Amount of Data to be reviewed

<table>
<thead>
<tr>
<th>Type of Data</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review and/or order clinical lab tests</td>
<td>1</td>
</tr>
<tr>
<td>Review and/or order tests in 7xxxxx of CPT</td>
<td>1</td>
</tr>
<tr>
<td>Review and/or order tests in 9xxxxx of CPT</td>
<td>1</td>
</tr>
<tr>
<td>Discuss test results with performing MD</td>
<td>1</td>
</tr>
<tr>
<td>Independent review of image, tracing or specimen</td>
<td>2</td>
</tr>
<tr>
<td>Decision to obtain old records and/or obtain history from others</td>
<td>1</td>
</tr>
<tr>
<td>Review and summarize old records/obtain history from other than patient/discuss case with other provider</td>
<td>2</td>
</tr>
</tbody>
</table>
## Table of Risk

<table>
<thead>
<tr>
<th>Level of Risk</th>
<th>Presenting Problem(s)</th>
<th>Diagnostic Procedure(s) Ordered</th>
<th>Management Options Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Minimal</strong></td>
<td>• One self-limited or minor problem, e.g. cold, insect bite, lice corporis</td>
<td>• Laboratory tests requiring venipuncture</td>
<td>• Rest</td>
</tr>
<tr>
<td></td>
<td>• Two or more self-limited or minor problems</td>
<td>• Chest x-rays</td>
<td>• Gargles</td>
</tr>
<tr>
<td></td>
<td>• One stable chronic illness, e.g., well controlled hypertension or non-insulin</td>
<td>• EKG/EEG</td>
<td>• Elastic bandages</td>
</tr>
<tr>
<td></td>
<td>dependent diabetes, cataract, BPH</td>
<td>• Urinalysis</td>
<td>• Superficial dressings</td>
</tr>
<tr>
<td></td>
<td>• Acute uncomplicated illness or injury, e.g., cystitis, allergic rhinitis, simple</td>
<td>• Ultrasound, e.g., echocardiography</td>
<td></td>
</tr>
<tr>
<td></td>
<td>sprain</td>
<td>• KOH prep</td>
<td></td>
</tr>
<tr>
<td><strong>Low</strong></td>
<td>• Two or more self-limited or minor problems</td>
<td>• Physiologic tests not under stress, e.g., pulmonary function tests</td>
<td>• Over-the-counter drugs</td>
</tr>
<tr>
<td></td>
<td>• One stable chronic illness, e.g., well controlled hypertension or non-insulin</td>
<td>• Non-cardiovascular imaging studies with contrast, e.g., barium enema</td>
<td>• Minor surgery with no identified risk factors</td>
</tr>
<tr>
<td></td>
<td>dependent diabetes, cataract, BPH</td>
<td>• Superficial needle biopsies</td>
<td>• Physical therapy</td>
</tr>
<tr>
<td></td>
<td>• Acute uncomplicated illness or injury, e.g., cystitis, allergic rhinitis, simple</td>
<td>• Clinical laboratory tests requiring arterial puncture</td>
<td>• Occupational therapy</td>
</tr>
<tr>
<td></td>
<td>sprain</td>
<td>• Skin biopsies</td>
<td>• IV fluids without additives</td>
</tr>
<tr>
<td><strong>Moderate</strong></td>
<td>• One or more chronic illnesses with mild exacerbation, progression, or side effects</td>
<td>• Physiologic tests under stress, e.g., cardiac stress test,</td>
<td>• Minor surgery with identified risk factors</td>
</tr>
<tr>
<td></td>
<td>of treatment</td>
<td>fetal contraction stress test</td>
<td>• Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors</td>
</tr>
<tr>
<td></td>
<td>• Two or more stable chronic illnesses</td>
<td>• Diagnostic endoscopies with no identified risk factors</td>
<td>• Prescription drug management</td>
</tr>
<tr>
<td></td>
<td>• Undiagnosed new problem with uncertain prognosis, e.g., lump in breast</td>
<td>• Deep needle or incisional biopsy</td>
<td>• Therapeutic nuclear medicine</td>
</tr>
<tr>
<td></td>
<td>• Acute illness with systemic symptoms, e.g., pyelonephritis, pneumonitis, colitis</td>
<td>• Cardiovascular imaging studies with contrast and no identified</td>
<td>• IV fluids with additives</td>
</tr>
<tr>
<td></td>
<td>• Acute complicated injury, e.g., head injury with brief loss of consciousness</td>
<td>risk factors, e.g., arteriogram, cardiac catheterization</td>
<td>• Closed treatment of fracture or dislocation without manipulation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Obtain fluid from body cavity, e.g., lumbar puncture, thoacentesis,</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>culdocentesis</td>
<td></td>
</tr>
<tr>
<td><strong>High</strong></td>
<td>• One or more chronic illnesses with severe exacerbation, progression, or side effects</td>
<td>• Cardiovascular imaging studies with contrast with identified</td>
<td>• Elective major surgery (open, percutaneous, or endoscopic) with identified risk factors</td>
</tr>
<tr>
<td></td>
<td>of treatment</td>
<td>risk factors</td>
<td>• Emergency major surgery (open, percutaneous, or endoscopic)</td>
</tr>
<tr>
<td></td>
<td>• Acute or chronic illnesses or injuries that may pose a threat to life or bodily</td>
<td>• Cardiac electrophysiological tests</td>
<td>• Parenteral controlled substances</td>
</tr>
<tr>
<td></td>
<td>function, e.g., multiple trauma, acute MI, pulmonary embolus, severe respiratory</td>
<td>• Diagnostic Endoscopies with identified risk factors</td>
<td>• Drug therapy requiring intensive monitoring for toxicity</td>
</tr>
<tr>
<td></td>
<td>distress, progressive severe rheumatoid arthritis, psychiatric illness with</td>
<td>• Discography</td>
<td>• Decision not to resuscitate or to de-escalate care because of poor prognosis</td>
</tr>
<tr>
<td></td>
<td>potential threat to self or others, peritonitis, acute renal failure</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• An abrupt change in neurologic status, e.g., seizure, TIA, weakness, or sensory loss</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Combined Elements of MDM

<table>
<thead>
<tr>
<th>Decision Making (2/3)</th>
<th>Straight Forward</th>
<th>Low</th>
<th>Moderate</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td># diag/mgmt options</td>
<td>Minimal (1)</td>
<td>Limited (2)</td>
<td>Multiple (3)</td>
<td>Extensive (4+)</td>
</tr>
<tr>
<td>Amt. of data to be reviewed</td>
<td>Minimal/None (1)</td>
<td>Limited (2)</td>
<td>Moderate (3)</td>
<td>Extensive (4+)</td>
</tr>
<tr>
<td>Risk (refer to table of risk)</td>
<td>Minimal (1)</td>
<td>Low (2)</td>
<td>Moderate (3)</td>
<td>High (4)</td>
</tr>
</tbody>
</table>
# Outpatient Visit E/M Codes

## Office Visit – New Patient

<table>
<thead>
<tr>
<th>Hx</th>
<th>Exam</th>
<th>MDM</th>
<th>Level 3/3</th>
</tr>
</thead>
<tbody>
<tr>
<td>PF</td>
<td>PF</td>
<td>SF</td>
<td>99201</td>
</tr>
<tr>
<td>EPF</td>
<td>EPF</td>
<td>SF</td>
<td>99202</td>
</tr>
<tr>
<td>Det.</td>
<td>Det.</td>
<td>Low</td>
<td>99203</td>
</tr>
<tr>
<td>Comp</td>
<td>Comp</td>
<td>Mod</td>
<td>99204</td>
</tr>
<tr>
<td>Comp</td>
<td>Comp</td>
<td>High</td>
<td>99205</td>
</tr>
</tbody>
</table>

## Office Visit – Established Patient

<table>
<thead>
<tr>
<th>Hx</th>
<th>Exam</th>
<th>MDM</th>
<th>Level 2/3</th>
</tr>
</thead>
<tbody>
<tr>
<td>--</td>
<td>--</td>
<td>--</td>
<td>99211</td>
</tr>
<tr>
<td>PF</td>
<td>PF</td>
<td>SF</td>
<td>99212</td>
</tr>
<tr>
<td>EPF</td>
<td>EPF</td>
<td>Low</td>
<td>99213</td>
</tr>
<tr>
<td>Det</td>
<td>Det</td>
<td>Mod</td>
<td>99214</td>
</tr>
<tr>
<td>Comp</td>
<td>Comp</td>
<td>High</td>
<td>99215</td>
</tr>
</tbody>
</table>
CC: Sore throat
HPI: Patient is a 15 year old male who presents with a sore throat which began three days ago.
ROS: Negative for fevers or chills; positive for mild malaise

Physical Exam
General appearance: No acute distress; conversant.
Vitals: 98.6, 72, 20, 110/74
HEENT: Oropharynx is clear with no mucosal ulcerations; normal posterior pharynx without erythema or exudate. External auditory canals patent with pearly TMs
Lungs: CTA with normal respiratory effort and no intercostal retractions

Assessment
• Viral URI.

Plan: Push fluids, Tylenol as needed, return to clinic if no improvement in 7 to 10 days
E/M Coding Example- Est. Patient

CC: “knee pain.”

Interval History: Patient with known osteoarthritis which had been previously controlled on Tylenol. Now states his left knee has been aching for about two weeks despite two to three doses of Tylenol per day.

ROS: Musculoskeletal--Negative for arthralgias or worsening joint pain elsewhere

Physical Exam
Mild swelling of left knee compared to the right. Some pain with passive rotation. No overlying warmth or erythema.

Assessment
- Worsening osteoarthritis
- Plan Start OTC ibuprofen 400 mg po TID, PRN
- Return visit in two weeks if no improvement
Proposed Documentation Changes to 2018 CMS PFS Final Rule

- Coding based on time
- Emphasis on Medical Decision Making
- Quality Outcomes
- Direct Primary Care Model
**Coding Based on Time**

**CC:** follow-up dyslipidemia

**Interval history:** The patient is here to ask why he needs to stay on statin medication for cholesterol. Most recent LDL was 131

**Exam:** BP 144/90

**Assessment** Dyslipidemia, Borderline hypertension

Plan Continue statin therapy

Recheck blood pressure at next visit

A total of 15 minutes were spent face-to-face with the patient during this encounter and over half of that time was spent on counseling and coordination of care. We discussed in depth the importance of primary prevention of coronary disease with aggressive treatment of high cholesterol. I also educated the patient about lifestyle modifications which may improve blood pressure
Medical Decision Making

- Increased emphasis on Medical Decision Making
- Decreased emphasis on History and Exam components
- Medical Necessity?
- Consequences of decreased documentation?
Rule Comments

- Commenters suggested that we provide additional avenues for collaboration with stakeholders prior to implementing any changes. We will consider the best approaches for such collaboration, and will take the public comments into account as we consider the issues for future rulemaking.
Future of Coding

- How will the proposed documentation guideline changes affect coding?

- Clinical Providers view coding under the current system as an administrative burden.
Quality Measures

- PHQ-2- Depression Screening
- PHQ-9- Positive Depression Screening

The Patient Health Questionnaire-2 (PHQ-2)

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Date of Visit</th>
</tr>
</thead>
</table>

Over the past 2 weeks, how often have you been bothered by any of the following problems?

<table>
<thead>
<tr>
<th></th>
<th>Not At all</th>
<th>Several Days</th>
<th>More Than Half the Days</th>
<th>Nearly Every Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Feeling down, depressed or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
Quality Measures

- Audit-C - Alcohol screening

AUDIT-C Questionnaire

Patient Name ________________________________ Date of Visit ____________________

1. How often do you have a drink containing alcohol?
   - □ a. Never
   - □ b. Monthly or less
   - □ c. 2-4 times a month
   - □ d. 2-3 times a week
   - □ e. 4 or more times a week

2. How many standard drinks containing alcohol do you have on a typical day?
   - □ a. 1 or 2
   - □ b. 3 or 4
   - □ c. 5 or 6
   - □ d. 7 to 9
   - □ e. 10 or more

3. How often do you have six or more drinks on one occasion?
   - □ a. Never
   - □ b. Less than monthly
   - □ c. Monthly
   - □ d. Weekly
   - □ e. Daily or almost daily
Direct Primary Care Model

- Provides family or primary care physicians a way of providing care without fee-for-service insurance billing.
Direct Primary Care Model: What it looks like

Mountain Medical Arts – Direct Primary Care (DPC) Facts

Mountain Medical Arts Membership:

- $49 per month (comprehensive visit may be done after 6 months are paid)
- Children (up to 18) of an adult member will be $20 per month extra.
- A family maximum of $150/month
- Each in person office encounter will be a $20 fee (checkups)
- If we need to see you at home $125 (subject to schedule availability and distance from office)
- Dr. Rothe Osteopathic fees (with membership) $60 for each 40 minute session, $70 if coordinated with medical checkup
- Integrative Consult and Coordination of Care: $89/month X 6 months = $540

Nonmember active patient à la carte prices:

- To be active must have a yearly Wellness Checkup: no charge for common labs once a year $249
- Each office encounter (Single problem such as urinary or respiratory infection) $65
- Osteopathic evaluation $200 initial $150 follow up or $300 if other medical advice needed
- Integrative Medicine Consults $250 first visit and $100 per 30 minute follow up
- School sports, college or camp physical and completion of forms $50
- DOT/CDL $150 (doesn’t require being an “active” patient)

Benefits:

- Unhurried appointments – freed from excessive paperwork, we are less likely to run behind (emergencies do still happen) formerly spent on insurance requirements, time which can now be spent on you.
- Transparent and realistic billing pricing. Working with other DPC doctors gives us a collective buying power which will get you the very best prices for medications (80% less than Walmart in some cases), lab work, and other services. You will never get a surprise bill from us.
Questions/Comments

- Thoughts/Comments on CMS revising E/M Documentation Guidelines?

- Thoughts/Comments on how this will affect coding and the profession?

- What will be the result if clinicians are not heard and documentation guidelines don’t change?