

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

PHYSICIAN USE OF NEW VISIT CODES



JUNE GIBBS BROWN
Inspector General

MAY 1995
OEI-04-92-01060

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EXECUTIVE SUMMARY

PURPOSE

To determine whether or not physicians uniformly and accurately use new visit codes adopted by the Health Care Financing Administration in 1992.

BACKGROUND

The Health Care Financing Administration (HCFA) bases Medicare payments to physicians partly on a system of five-digit codes. Generally, the codes represent type and complexity of service provided, and patient status, such as new or established. Medicare payments are generally higher for more complex and longer visits.

Effective in 1992, HCFA adopted new visit codes developed by the American Medical Association (AMA). The AMA revised the previous coding system used by Medicare, and redefined physician services those codes represent.

The revised codes were designed to improve coding uniformity and accuracy. Uniform coding is achieved when codes physicians submit to Medicare reflect a consistent pattern throughout a universe of physicians. Accurate coding is achieved when physicians select codes which consistently fit the services physicians actually provided.

METHODOLOGY

We drew our data from two sources.

First, we surveyed eight randomly selected Medicare carriers to determine how they implemented and monitored the new codes. As part of that effort, we asked appropriate personnel from each carrier to code clinical vignettes to measure carrier accuracy and consistency in selecting correct codes. All eight carriers responded to our survey.

Second, we randomly surveyed 328 physicians concerning their experiences with the new visit codes. Despite a number of follow-up attempts, only 61 physicians (18 percent) responded to our survey. Of the 328 physicians surveyed, 101 were primary care physicians. We asked the primary care physicians to code five clinical vignettes designed to measure how accurately and consistently physicians chose correct codes. Of the 101 primary care physicians, 14 (13 percent) completed the vignettes.

Because of low response rates to the physician survey, we cannot draw definitive conclusions regarding the experience of physicians in using new visit codes or their understanding of new visit codes. Nonetheless, we believe the data we did obtain may provide useful insight to HCFA. Therefore, we presented it in this report.

CARRIERS HAVE DIFFICULTY SELECTING NEW CODES

None of the five vignettes were coded the same way by all sampled carriers, which illustrates carrier difficulty understanding the new visit codes. The vignettes were coded with a one level discrepancy, or carriers conceded they were unable to decide between two possible codes. Further, most carriers said (1) code definitions are not clear, and (2) they believe that physicians are not using the codes uniformly and accurately.

PHYSICIANS HAD DIFFICULTY SELECTING CODES

The 14 physicians who coded our test vignettes also demonstrated difficulty selecting the codes accurately. Only 1 of the 14 physicians coded all 5 of the vignettes correctly as defined by the AMA. Many of the 61 physicians who responded to our survey frequently delegate code selection to their office staff.

CARRIERS HAVE TAKEN LIMITED ACTION TO ENFORCE COMPLIANCE WITH NEW VISIT CODES

Carriers we surveyed said that, since the new visit codes were implemented in 1992, they have taken virtually no action against physicians for submitting improperly coded claims.

RECENT HCFA GUIDANCE MAY IMPROVE CODING UNIFORMITY AND ACCURACY

Since the time of our survey, HCFA and the AMA have collaborated on, and disseminated medical record documentation guidelines. HCFA staff expect the guidelines to result in more uniform and accurate coding. The guidelines, issued in November 1994, are designed to clarify criteria for visit codes.

CONCLUSIONS

Because of limited responses by physicians, the information presented in this report should be viewed as preliminary. We make no recommendations. However, our data does raise concerns or questions about use of new visit codes. Those concerns are (1) the accuracy of codes selected by physicians, (2) the ability of carriers to correctly advise physicians on coding matters, and (3) the extent to which carriers effectively and appropriately monitor physician use of the codes. These concerns will be addressed in future reports by the OIG.

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INTRODUCTION

PURPOSE

To determine whether or not physicians uniformly and accurately use new visit codes adopted by the Health Care Financing Administration in 1992.

BACKGROUND

The Health Care Financing Administration (HCFA) bases Medicare payments to physicians partly on a system of five-digit codes. Generally, the codes represent type and complexity of service provided, and patient status, such as new or established. Medicare payments are generally higher for more complex and longer visits. For example, a Medicare patient visit involving an in-depth examination for symptoms indicative of cancer would receive a higher payment code than a less complex visit for symptoms of a common cold.

Medicare Pre-1992 Visit Codes and Related Problems

From 1983 through 1991, the coding system used by HCFA did not result in uniform and accurate billing by physicians. Over that time period, various organizations, including Medicare carriers, Office of Inspector General (OIG), and HCFA identified coding problems that led to inappropriate Medicare payments.

For example, in 1989, an OIG inspection report (OAI-04-88-00700) showed that the coding system did not evidence "even a semblance of the uniformity sought" in physician billing. Physician use of codes for billing Medicare varied widely. Based partly on the OIG report, the American Medical Association (AMA), HCFA, and other agencies have studied the coding system over the last several years. The OIG and other reviewers generally described the coding problems as follows.

- ▶ Vague code descriptions resulted in differences in physician interpretation of services each code represented.
- ▶ Physicians apparently sought to maximize reimbursement by billing a higher level code than appropriate for services rendered.
- ▶ HCFA and Medicare carriers did not consistently review and challenge coding practices by physicians.

New Visit Codes

Effective in 1992, HCFA adopted new visit codes developed by the AMA. That is, AMA revised the previous coding system Medicare and other insurers use. The AMA also redefined the physician services those codes represent. Like the previous codes, the new codes consist of five digits.

The revised codes were designed to improve coding uniformity and accuracy. Although coding uniformity and accuracy are related goals, the terms are not synonymous. Uniform coding is achieved when codes physicians submit to Medicare reflect a consistent pattern throughout a universe of physicians. For example, five new codes represent the five alternative levels of complexity which gauge services physicians provide during office visits with established patients. If, nationally, physicians select the third level code about 52 percent of the time, but physicians in several States select it only about 30 percent of the time -- that would be a lack of uniformity.

Coding accuracy is achieved when physicians select codes which fit the services actually provided. Using the above scenario as an example, any time a particular physician selects a code which represents an office visit of lesser or greater complexity than that which was actually provided -- that is inaccurate coding. Generally, to assess coding accuracy, a Medicare carrier must review a physician's medical records supporting specific services that were billed.

The pre-1992 visit codes included virtually no descriptive information which physicians could use to accurately select a code. Those codes represented services which were described only as "brief," "limited," or similar subjective wording. Contrastingly, the revised definitions established much more specific, but elaborate, criteria for each code. The revised definitions included up to seven components of a visit. They were (1) medical history, (2) examination, (3) medical decision making, (4) counseling, (5) coordination of care, (6) nature of the presenting problem, and (7) an estimated amount of time physicians typically spend providing a service. The codes for the more complex services require more components than do codes for less complex services.

The new coding system also reduces the number of codes available for use. This change was designed to reduce opportunities for erroneous interpretation of codes when physicians bill for services.

METHODOLOGY

We conducted structured interviews with HCFA headquarters staff to determine procedures HCFA used to implement the new visit codes.

We surveyed eight randomly selected Medicare carriers to determine how they implemented and monitored the new codes. We mailed each carrier a standardized questionnaire. All eight carriers completed our questionnaire. However, we supplemented the written responses by visiting one carrier and telephoning the remaining

seven. We also asked appropriate personnel from each carrier to code five clinical vignettes to measure carrier accuracy and uniformity in selecting codes.

We surveyed 328 physicians to determine how they used the new codes. We used HCFA's automated Unique Physician Identification Numbers file to randomly sample 360 physicians who were served by one of the eight Medicare carriers we had selected. However, we dropped 32 physicians from our sample because of unknown addresses, deaths, and retirements. We mailed standardized questionnaires to the remaining 328 physicians. A total of 61 physicians returned completed questionnaires, for a response rate of 18 percent. Physician participation in our survey was voluntary.

Our sample of 328 physicians included 101 primary care physicians. Primary care physicians are those in family and general practice and those in internal medicine. To determine if physicians uniformly and accurately use the new codes, we asked the primary care physicians to code five clinical vignettes as they would code an actual office visit. We did not send test vignettes to sampled physicians in other specialties because the number of sampled physicians in any one specialty was very small.

The 101 primary care physicians to whom we sent vignettes included 56 family and general practitioners and 45 internists. We sent one set of five vignettes to family and general practitioners, and a different set of five to internists. The set we sent to family and general practitioners was the same as the set we sent to carriers. Fourteen physicians coded and returned the vignettes -- a completion rate of 13 percent. Appendix A shows the vignettes we sent to family and general practitioners and carriers. Appendix B shows the vignettes we sent to internists.

The vignettes we used were furnished to us by the AMA. The AMA also provided the appropriate visit code for each vignette. We used AMA's coding as a standard for determining if physicians coded the vignettes accurately.

Because of the low response rates to the physicians' survey, we cannot draw definitive conclusions regarding the experience of physicians in using new visit codes. Nonetheless, we believe the data we obtained will provide useful insights to HCFA and are therefore presented in this report.

We conducted this inspection in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

FINDINGS

CARRIERS HAVE DIFFICULTY SELECTING NEW CODES

Lack of Coding Uniformity among Carriers

To assess coding uniformity, we analyzed responses to five test vignettes coded by the eight sampled carriers.

The vignettes we sent to carriers described office visits provided by a physician to an established patient. Five new visit codes represent various levels of complexity for office visits with such patients. The codes are 99211, 99212, 99213, 99214, and 99215.

Notably, none of the five vignettes were coded the same way by all sampled carriers. The vignettes were coded with a one level discrepancy, or carriers conceded they were unable to decide between two possible codes. The following pattern was typical.

- ▶ In coding one of the vignettes, three carriers selected code 99214, while three carriers selected 99215. The other two carriers were unable to decide between those two codes. The correct code, according to the AMA, was 99215.
- ▶ For another vignette, four carriers selected code 99214, and three carriers selected 99215. The remaining carrier was unable to decide between 99214 and 99215. The correct code was 99214, according to AMA.
- ▶ For another vignette, three carriers selected code 99213. Four carriers selected 99214. The remaining carrier was unable to decide between 99213 and 99214. The correct code was 99214, according to AMA.

The lack of uniform coding was similar to HCFA findings in 1992. To assess uniformity, HCFA staff in a regional office had 4 Medicare carriers code 14 actual physician visits. The carriers coded the visits based on medical records supplied by physicians who had submitted Medicare claims. The visits were for hospital and other types of medical care. None of the 14 visits, however, were coded the same way by all 4 carriers. HCFA found that the 4 carriers selected between 2 and 4 different codes for each of the 14 visits.

- ▶ Ten visits were coded two different ways.
- ▶ Three visits were coded three different ways.
- ▶ One visit was coded four different ways.

Lack of Clear Code Definitions

Six of the eight carriers we surveyed said the new visit codes are not clear. Most of those carriers said lack of clear definitions was the root cause of most coding problems.

For example, one carrier specified that a clearer definition was needed to differentiate two levels of medical history and examination -- "problem focused" history and examination, as opposed to "extended problem focused" history and examination. Those terms are part of the definitions for office visit codes 99212 and 99213, respectively. The terms are supposed to help physicians differentiate the levels of complexity those two codes represent. Specifically, the levels of history and examination are two criteria for selecting code 99212 or 99213.

Further describing the lack of clarity in the code definitions, another carrier stated that clarification was needed regarding how to properly evaluate medical decision making. The carrier also stated that clarification was needed on how to determine the degree of documentation needed to support each code level. For example, what documentation is needed on initial examinations as opposed to subsequent examinations. Some carriers also said they need examples of proper support documentation. (Subsequent to our survey, HCFA issued medical documentation guidelines to carriers.)

Citing another aspect of the new codes for which they believe clarification is needed, several carriers said that they and physicians need more published vignettes giving examples of proper coding. They especially cited a need for vignettes on services to elderly persons with multiple ailments.

Carriers Report Lack of Coding Uniformity and Accuracy among Physicians

We also asked carriers for their views about coding uniformity and accuracy. As Tables 1 and 2 indicate, only carriers # 2 and # 4 in our sample believe that physicians are using the codes uniformly and accurately. The eight sampled carriers based their opinions that physicians used the new codes inaccurately or accurately on reviews of physician coding practices and medical records of patients. All of the carriers reported reviewing samples of Medicare claims and supporting documentation, as required by HCFA. However, in light of their own difficulties with choosing correct codes, carrier opinions should be viewed with some caution.

TABLE 1

CARRIER OPINIONS ON UNIFORMITY OF CODING BY PHYSICIANS			
CARRIER	UNIFORM	NONUNIFORM	DON'T KNOW
Carrier # 1		X	
Carrier # 2	X		
Carrier # 3	X		
Carrier # 4	X		
Carrier # 5		X	
Carrier # 6			X
Carrier # 7		X	
Carrier # 8		X	
RESPONSE TOTALS	3	4	1

TABLE 2

CARRIER OPINIONS ON ACCURACY OF CODING BY PHYSICIANS			
CARRIER	ACCURATE	INACCURATE	DON'T KNOW
Carrier # 1	X		
Carrier # 2	X		
Carrier # 3		X	
Carrier # 4	X		
Carrier # 5			X
Carrier # 6			X
Carrier # 7		X	
Carrier # 8		X	
RESPONSE TOTALS	3	3	2

PHYSICIANS HAD DIFFICULTY SELECTING CODES

The 14 physicians who coded the test vignettes included in our survey also had difficulty selecting proper codes (see Table 3). The 14 physicians each coded 5 test vignettes. Only one physician had a perfect score, with five of five coded correctly as defined by the AMA.

TABLE 3

PHYSICIAN CODING OF TEST CLINICAL VIGNETTES	
	# OF PHYSICIANS
5 of 5 correct	1
4 of 5 correct	2
3 of 5 correct	6
2 of 5 correct	3
1 of 5 correct	1
0 of 5 correct	1
Physician total	14

Lack of Physician Involvement in Selecting Codes

Our survey of physicians showed that most do not personally select codes for Medicare claims. Table 4 shows that only about 48 percent (29 of 61) of the physicians who responded to our survey said they selected the codes for billing Medicare 100 percent of the time. About 16 percent of the physicians said they never select the codes. Thus, they always delegate code selection to their staff.

TABLE 4

PHYSICIAN INVOLVEMENT IN CODING MEDICARE CLAIMS		
FREQUENCY OF CODE SELECTION	# OF PHYSICIANS	% OF PHYSICIANS
100 % of the time	29	48 %
75 - 99 % of the time	13	21 %
1 - 74 % of the time	9	15 %
0 % of the time	10	16 %
Total	61	100 %

CARRIERS HAVE TAKEN LIMITED ACTION TO ENFORCE COMPLIANCE WITH NEW VISIT CODES

Carriers report that, since the new visit codes were implemented in 1992, they have taken virtually no action against physicians for submitting improperly coded claims.

During the first few months of 1992, HCFA instructed carriers to review claims, detect coding errors, and educate physicians accordingly. During 1992, at least four of the eight carriers we surveyed found error rates in excess of 25 percent. Such error rates might be expected the first few months after the new codes were implemented. Accordingly, HCFA took the approach of educating, rather than penalizing, physicians who used the wrong codes. However, since early 1992, physicians have had ample time to learn the new codes. Yet, carrier oversight and corrective actions have been minimal to date.

HCFA told us that carriers and physicians were disadvantaged without guidelines on visit code criteria and related medical documentation. However, HCFA's position is that carriers could take corrective action if physicians egregiously miscode claims.

Notwithstanding HCFA's position on corrective action, the carriers we surveyed clearly indicated an understanding to the contrary. For example, carriers said they believed that HCFA had instructed them not to correct codes erroneously billed by physicians, and not to take corrective action. Further, one carrier expressed an opinion that HCFA had even discouraged monitoring of the new visit codes. Information from another carrier illustrates carriers' understanding of HCFA's instructions regarding corrective actions. That carrier told us in May 1994 that some physicians were miscoding their claims and cited as an example a physician who billed all visits at the highest reimbursement level. The carrier did not complete an audit of the physician's claims until February 1995. The audit showed that all of 60 claims reviewed should have been denied or downcoded. In spite of such an egregious finding, however the carrier still felt the need to seek further guidance from HCFA. HCFA responded by acknowledging that carriers have been "restricted" in enforcing compliance with the new codes. However, HCFA restated its position that carriers, at their discretion, could take corrective action in egregious cases.

RECENT HCFA GUIDANCE MAY IMPROVE CODING UNIFORMITY AND ACCURACY

Subsequent to our surveys, HCFA issued guidelines to carriers on visit code criteria and supporting medical documentation. The guidelines, effective in November 1994, elaborate on visit code components such as medical history, examination, and medical decision making. HCFA reports that carriers are now engaged in an effort to educate physicians about the new guidelines. HCFA staff expect the guidelines to result in more uniform and accurate coding and more consistent medical review. Further, HCFA has provided carriers with computer software which can help them identify aberrant physician billing patterns. Potentially, carriers can use the software to lay a foundation for corrective actions against physicians who miscode Medicare claims. Beginning in August 1995, HCFA expects carriers to step up enforcement of the new visit codes.

CONCLUSIONS

Because of the limited physician response to our survey, we are not making recommendations. In light of the low response rates, the information we developed should be viewed as preliminary in nature. However, the data we collected in the course of our study raise certain questions. Among those questions are:

- ▶ How accurate are codes selected by physicians and/or their staffs when submitting claims to the Medicare program?
- ▶ In light of their own difficulty in selecting codes accurately, to what extent do carrier personnel have the ability to provide good advice to physicians and their staffs on coding matters?
- ▶ To what extent are carrier personnel effectively and appropriately monitoring physicians' use of codes?

Future OIG work is planned in all three of these areas to assess whether HCFA's new guidelines have the intended effect, and if so, how. HCFA expects its new guidelines to improve physician coding accuracy, carrier accuracy in giving advice, and carrier monitoring.

APPENDIX A

VIGNETTES CODED BY CARRIERS, AND FAMILY AND GENERAL
PRACTITIONERS

- A. A sixty-six year old white male presents to the family physician's office for a routine four month follow-up of his long standing hypertension and stable coronary artery disease. His past medical history is otherwise benign, and these chronic problems have remained stable for one to two years on single long acting calcium channel blocker. The patient, however, related the onset of new symptoms over the past four to six months including significant nocturia, hesitancy, and postvoid dribbling. A detailed examination is conducted including cardiac, pulmonary, and fundoscopic examinations. All are within normal limits and unchanged. His abdominal exam, however, suggests a distended bladder and his rectal examination reveals a significantly enlarged prostate which is smooth, symmetric, and not suggestive of carcinoma. The patient is continuing on his usual medications but is counseled regarding a presumptive diagnosis of benign prostatic hypertrophy. A routine urinalysis is obtained along with an electrolyte panel, including renal function studies. The patient was scheduled for a urological consultation regarding the need for a transurethral resection of the prostate. He is scheduled for routine follow-up in one month following the urology evaluation. Duration of the visit is 12-25 minutes.

Code: 99214

- B. A sixty-eight year old white female presents to the family physician's office with a known history of moderate hypertension and Type II diabetes mellitus. She has missed her two previous scheduled appointments. The patient is known to be relatively noncompliant with her medical regimen. She is complaining of excessive fatigue over the past two months and increased frequency of urination accompanied with polydipsia and polyphagia. Her chronic medications are supposed to include a calcium channel blocker and an oral hypoglycemia agent. She does have the facilities at home to monitor her blood pressure at home as well as a home glucose monitor. A detailed history and physical are completed during this visit and it is obvious that she has again been noncompliant with her medical regimen and noncompliant with her diet. A review of her blood pressure readings from home, as well as her blood glucose readings have revealed poor control both of her hypertension and her diabetes mellitus. Appropriate arrangement are made through a home health agency to provide dietary counseling and to provide nursing visits to assist in the assurance of medication compliance as well as for blood pressure and diabetic monitoring at home. A return appointment is made for one week to assure improvement in her clinical status. Duration of the visit was 20-25 minutes.

Code: 99214

- C. A seventy-seven year old black man presents to the family physician with a three month history of episodic substernal chest tightness with exertion. The patient is an established patient having been seen previously for routine physical exams and for other acute episodic illnesses. A complete history reveals the patient to be a long term abuser of tobacco, and he also has a very strong family history of coronary artery disease and hypertension. He states that his episodes of chest discomfort have been more progressive over the previous three months and now include radiation into his left shoulder and neck after limited exertion activity. The discomfort will usually subside within two or three minutes after exertion. A complete physical examination is undertaken which is unremarkable. Laboratory data reveals a normal chest x-ray and normal resting electrocardiogram. A presumptive diagnosis of coronary artery disease is made and the patient is prescribed a calcium channel blocker with the prn use of sublingual nitroglycerin. He is advised to discontinue his smoking and to limit his activities such that it is not to include heavy exertion or lifting. Specific counseling was also undertaken with the patient for coronary artery disease, risk factor modification. An appointment is made with a local cardiologist to schedule a submaximal exercise treadmill test and a follow-up appointment is scheduled in two weeks. Duration of time is 20-35 minutes.

Code: 99214

- D. A fifty year old white female presented to her family physician because of the onset of erythema, edema, and pain in the area of the plantar surface of the right third metatarsal. This is an established patient known for her insulin dependent diabetes who is taking a split dose of Humulin N each day. The patient also has hypertension, which is well controlled on Procardia XL 30 mg daily. The patient does have the capacity to monitor her glucoses at home. The patient denies any fever but has begun to note "red streaks" radiating up the medial aspect of her foot. A complete physical examination is performed and was benign except for an area of deep cellulitis on the plantar surface of the right foot near the distal third metatarsal. There was evidence of ascending lymphangitis. The patient's random glucose taken in the office was 250. The patient and her family were counseled at length regarding the acute diagnosis and the ability to provide appropriate care at home as an outpatient. Coordination of patient's care was then initiated through a home health agency to provide intravenous home antibiotic therapy and to assist the patient in monitoring her blood glucose control. Arrangements were also made for daily outpatient whirlpool treatments for appropriate debridement and cleansing of the right foot if an ulcer were to develop. A follow-up appointment in two days was assigned to the patient. Duration of the visit, including face-to-face time with the patient and her family, was 30 to 50 minutes.

Code: 99215

- E. A seventy year old female is brought to the family physician by her daughter because of the onset over a two-month period of confusion, agitation, and short term memory loss. The patient is well known to the physician because of the long standing history of hypertension and diet controlled diabetes mellitus. Her only medication is a thiazide diuretic. The patient is ambulatory but is clearly disoriented and becomes easily agitated. History obtained from the daughter suggests a possible history of a fall at home three to four months prior to this visit and no other trauma can be ascertained. A history and physical examination are conducted. This includes an extensive neurologic examination which reveals significant changes in the patient's mental status examination but no focal neurologic findings. Bilateral carotid bruits are detected but there is no cardiac murmur. Multiple diagnoses are considered including multi infarct dementia, subdural hematoma, Alzheimer's dementia, etc. Diagnostic testings is initiated, including a head scan and appropriate biochemical studies. A consultation is scheduled for a neurologic second opinion and a follow-up appointment is scheduled in two to three weeks. Her daughter is counseled concerning her mother's potential differential diagnosis and suggestion are made concerning increasing her support and stimulation at home through services offered by a local home health agency. A referral is made to this agency to assist the daughter with care of the patient at home. Duration of the visit spent with the patient and her family is 30-50 minutes.

Code: 99215

APPENDIX B

VIGNETTES CODED BY INTERNISTS

- A. This is a 79 year old man who has had multiple basal cell carcinomas of the head and neck removed in the past. He is seen today in a cancer surveillance follow-up program. He has no complaints.

You examine his skin and note no new lesions or recurrence of lesions from previous excision sites. You again educate him regarding sun exposure and schedule a follow-up appointment.

You spend 15 minutes face-to-face with the patient and/or family.

Code: 99213

- B. This is a 62 year old white female, established patient who is followed by you for primarily systolic hypertension. She presents in your office for a scheduled follow-up visit. She is on Dyazide. She has no complaints except for some urinary frequency. You obtain an interval history relating to her hypertension and GU symptomatology.

You check her blood pressure which is well controlled and order a potassium and a urinalysis.

You advise her to call tomorrow for the results.

You spend 15 minutes face-to-face with the patient and/or family.

Code: 99213

- C. A 55 year old obese white male established patient comes to your office for routine follow-up six months following an anterior myocardial infarction. His medications include Procardia XL 30 mg. p.o. q.d., and Tenormin 25 mg. for hypertension. You obtain an interval history which is unremarkable.

On examination, you note that his weight is down from 285 to 265 pounds. His height is 6'1" and his blood pressure is 105/65. He appears obese. His lungs are clear. You note an atrial diastolic gallop.

You counsel him with regard to cholesterol management and advise him to continue his weight reduction and activity level. You make a note to consider dropping the Tenormin if his blood pressure remains stable. You schedule a return visit in one month.

You spend 15 minutes face-to-face with the patient and/or family.

Code: 99213

- D. A 68 year old white female established patient presents to your office with a known history of moderate hypertension and Type II diabetes mellitus. She has missed her two previous scheduled appointments. She is known to be relatively noncompliant with her medical regimen. She complains of excessive fatigue over the past two months and increased frequency of urination accompanied with polydipsia and polyphagia. Her chronic medications are supposed to include a calcium channel blocker and an oral hypoglycemic agent. She has the equipment at home to monitor her blood pressure and her blood glucose. You perform a detailed history and determine that she has again been noncompliant with her medical regimen and her diet. You review her blood pressure readings from home, as well as her blood glucose readings and note poor control of her hypertension and her diabetes.

You perform a detailed physical.

You adjust her hypertensive medication and arrange dietary counseling and nursing visits through a home health agency to assist in the assurance of medication compliance. You make a return appointment for one week to assure improvement in her clinical status.

You spend 35 minutes face-to-face with the patient and/or family.

Code: 99214

- E. An unemployed 60 year old man, a chronic heavy drinker of ethanol and smoker of cigarettes (two packs per day for 40 years), is brought to your office by his daughter. He has had gradual progressive shortness of breath for 2 years and a long-term daily cough, usually productive of clear phlegm. However, 5 days ago, after binge drinking, he notices that the phlegm was no longer clear but purulent and occasionally streaked with blood. The patient was told that he had a positive tuberculin skin test many years ago, but he never received antituberculosis medication.

Your physical examination reveals the patient to be alert but weak, disheveled, and ill-appearing. His mouth and gums are in poor condition. There is no adenopathy. Examination of the chest reveals scattered wheezes and a prolonged expiratory phase. There is clubbing of his fingers, but the rest of his physical examination shows no abnormalities.

You order laboratory studies and send the patient to the second floor of your professional building for a chest x-ray. Within 20 minutes the radiologist reports that the roentgenograph of the chest shows an irregular, thick walled cavitary lesion in the right lung.

The patient and his daughter come into your office where you tell them of the findings on the x-ray and suggest hospitalization. The patient becomes agitated,