Family Practice Management®
www.aafp.org/fpm

September/October 2011

E/M Coding and the Documentation Guidelines: Putting It All Together 33

AAFP MEMBERS AND PRINT SUBSCRIBERS:

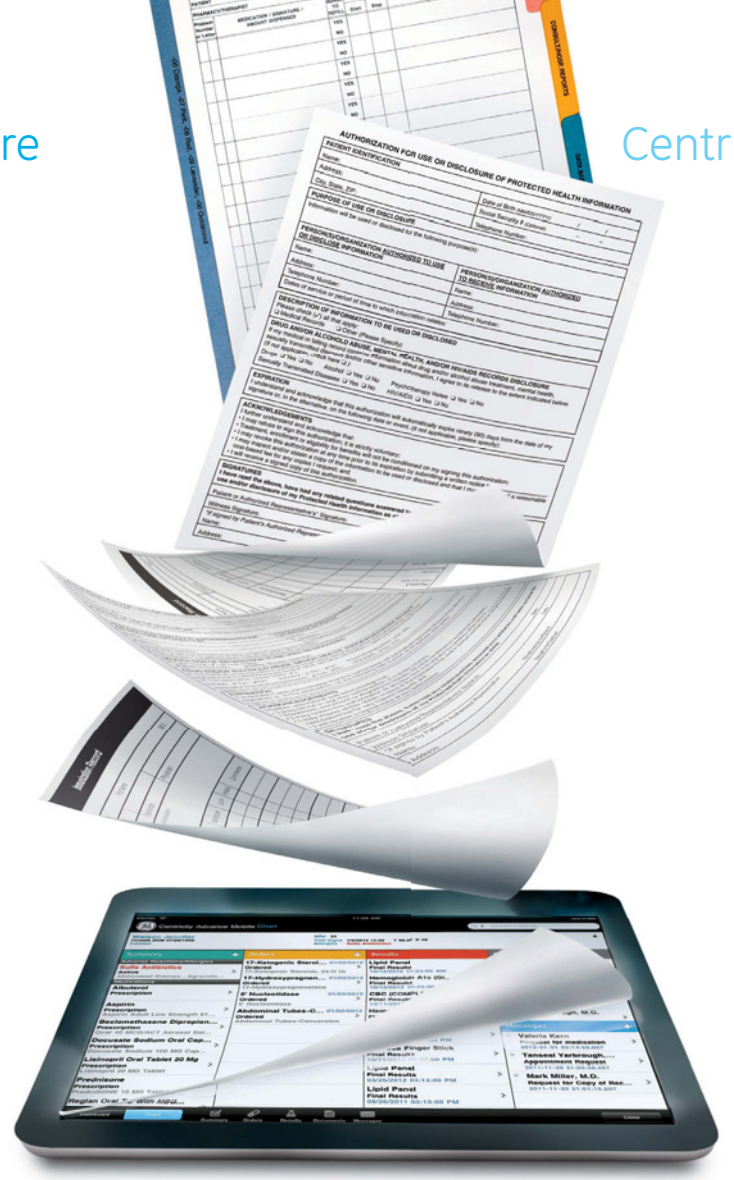
EARN 3.25 CME CREDITS

Take the CME Quiz online at
http://www.aafp.org/fpmquiz
(Preview the questions on page 41.)

AMERICAN ACADEMY OF FAMILY PHYSICIANS

GE Healthcare

Centricity Advance



Paper records are so 20th century.

We'll help you through your EMR transition, every step of the way.

Your small practice is ready for the clinical and financial benefits of an EMR. With Centricity Advance from GE Healthcare, you can reap them in weeks, not months—at a low monthly fee. And as your partner, we'll be there to support your transition every step of the way, from setup and training to achieving meaningful use. So before long, you'll experience new levels of efficiency—and we're certain you won't miss paperwork a bit.

Learn more today—visit www.gehealthcare.com/emrpartner or call 800-535-7921.

imagination at work

© 2011 General Electric Company

Family Practice Management®

September/October 2011 Vol. 18 No. 5

FEATURES

continued ➤

TOOLS IN THIS ISSUE

➤ **ICD-9 Codes for Family Medicine: The *FPM* Short List**

See the insert following page 24.

➤ **The Evaluation and Management Guidelines at a Glance**

See page 36.

These tools are among 150+ tools available online in the *FPM* Toolbox at **www.aafp.org/fpm.**

COMING SOON

- Communicating Bad News to Your Patients

CONNECT WITH *FPM*

Follow us on Twitter at **http://www.twitter.com/FPMjournal**

Be our fan on Facebook at **http://www.facebook.com/FPMjournal**

Cover illustration by Adam Niklewicz, a North Haven, Conn.-based illustrator who has worked with prominent clients such as Business Week *and* USA Today.

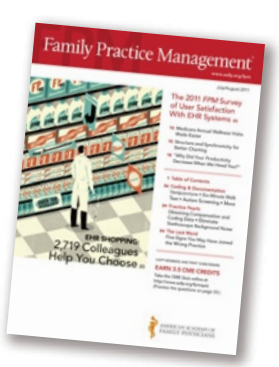
FROM TOP TO BOTTOM: RON CHAN, SEAN KANE

DEPARTMENTS

PREFER *FPM* IN PRINT?

You can still get the *FPM* print edition that you know and love! Subscribe for just $30 (for AAFP members) and have it delivered to you six times a year.

Go to http://www.aafp.org/fpm/subscribe or call 800-274-2237.



To sign up to receive *FPM* by e-mail, visit http://www.aafp.org/fpm/digitalfpm.

FPM is indexed in MEDLINE, PubMed and Cumulative Index to Nursing & Allied Health Literature. The journal is available in full text at http://www.aafp.org/fpm, and *FPM* content is available online through EBSCO and MD Consult.

Family Practice Management (ISSN 1069-5648) is published six times a year by the Publications Division of the American Academy of Family Physicians, 11400 Tomahawk Creek Parkway, Leawood, Kansas 66211-2680. Phone: 800-274-2237. Periodicals postage paid at Shawnee Mission, Kansas, and at additional mailing offices. Printed in the U.S.A.

Copyright © 2011 by the American Academy of Family Physicians.

Postmaster: Send address changes to *Family Practice Management*, 11400 Tomahawk Creek Parkway, Leawood, KS 66211-2680.

AAFP

Published by the American Academy of Family Physicians

AMM

The information and opinions presented in *FPM* reflect the views of the authors, not those of the journal or the AAFP, unless so stated. The staff makes every reasonable effort to provide accurate, authoritative information, but *FPM* is intended only as a guide; it does not replace coding manuals and other such resources.

It is the policy of the AAFP that all *FPM* authors and editors disclose relationships with commercial entities before their role in developing editorial content is confirmed. Disclosure documents are reviewed for potential conflicts of interest. If conflicts are identified, they are resolved before confirmation of participation. Only those who have no conflicts of interest or whose conflicts have been successfully resolved were involved in this CME activity. We publish a disclosure statement with each relevant article, and we inform readers of any pertinent relationships disclosed.

FPM accepts advertising judged to be in harmony with the purpose of the journal. Acceptance does not constitute endorsement by *FPM* or the AAFP.

Educational Objectives

Family Practice Management aims to promote the ideals of family medicine and to help readers improve their knowledge and skills in several areas:

- High-quality, cost-effective patient care
- Effective, ethical practice in managed care
- Computerizing practice and maximizing the usefulness of computers
- Diagnosis and procedure coding
- Career and practice development
- Developments in Medicare and other federal health care programs
- The evolving health care system and the place of family medicine in it
- Balancing the demands of professional and personal life
- Developing and exercising leadership skills

For patients with type 2 diabetes whose blood glucose is not well controlled with orals alone

ADVERTISEMENT

IS IT TIME TO RETHINK INSULIN?

Indications and Usage for Lantus® (insulin glargine [rDNA origin] injection)

Lantus® is a long-acting insulin analog indicated to improve glycemic control in adults and children (6 years and older) with type 1 diabetes mellitus and in adults with type 2 diabetes mellitus. Lantus® should be administered once a day at the same time every day.

Important Limitations of Use: Lantus® is not recommended for the treatment of diabetic ketoacidosis. Use intravenous short-acting insulin instead.

Important Safety Information for Lantus®

Contraindications

Lantus® is contraindicated in patients hypersensitive to insulin glargine or one of its excipients.

Warnings and Precautions

Monitor blood glucose in all patients treated with insulin. Insulin regimens should be modified cautiously and only under medical supervision. Changes in insulin strength, manufacturer, type, or method of administration may result in the need for a change in insulin dose or an adjustment in concomitant oral antidiabetic treatment.

Do not dilute or mix Lantus® with any other insulin or solution. If mixed or diluted, the solution may become cloudy, and the onset of action/time to peak effect may be altered in an unpredictable manner. Do not administer Lantus® via an insulin pump or intravenously because severe hypoglycemia can occur. Insulin devices and needles must not be shared between patients.

Please see additional Important Safety Information for Lantus® continued on the next page.

From the maker of

LANTUS® SoloSTAR®

For patients with type 2 diabetes whose blood glucose is not well controlled with orals alone

THIS IS NOT JUST A TIRE

IT'S SOMETHING WE TAKE FOR GRANTED UNTIL IT'S WEARING OUT

Important Safety Information for Lantus® (insulin glargine [rDNA origin] injection) *(cont'd)*

Warnings and Precautions *(cont'd)*

Hypoglycemia is the most common adverse reaction of insulin therapy, including Lantus®, and may be life-threatening.

Severe life-threatening, generalized allergy, including anaphylaxis, can occur.

A reduction in the Lantus® dose may be required in patients with renal or hepatic impairment.

Drug Interactions

Certain drugs may affect glucose metabolism, requiring insulin dose adjustment and close monitoring of blood glucose. The signs of hypoglycemia may be reduced in patients taking anti-adrenergic drugs (e.g., beta-blockers, clonidine, guanethidine, and reserpine).

Adverse Reactions

Other adverse reactions commonly associated with Lantus® are injection site reaction, lipodystrophy, pruritus, and rash.

Please see additional Important Safety Information for Lantus® continued on the next page.

sanofi aventis
Because health matters

© 2011 sanofi-aventis U.S. LLC

JUST LIKE THE PANCREAS

Don't delay—consider prescribing insulin to help lower blood glucose for your appropriate patients.

Your patients may be more willing than you think...

In a survey, about 80% of patients with type 2 diabetes taking oral antidiabetic drugs said they would consider taking insulin based on your recommendation.[1]

Get tips for having a conversation about insulin and access to patient resources at:

www.RethinkInsulin.com

Important Safety Information for Lantus® SoloSTAR®

Lantus® SoloSTAR® is a disposable prefilled insulin pen. To help ensure an accurate dose each time, patients should follow all steps in the Instruction Leaflet accompanying the pen; otherwise they may not get the correct amount of insulin, which may affect their blood glucose.

Please see brief summary of full prescribing information for Lantus® on the following pages.

SCANLIFE

Scan the QR code with your smartphone to access and download helpful patient support materials.

Here's how to get started:

— Open your mobile browser and visit 2dscan.com, search for 'ScanLife' in your app store or text "SCAN" to 43588

— Follow the prompts to download the free application

— Using the application, take a photo of the QR code through the ScanLife application and you'll be taken directly to patient resources

INSULIN

IMPROVING BLOOD GLUCOSE CONTROL SHOULDN'T WAIT

Reference: 1. Data on file, sanofi-aventis U.S. LLC.

LANTUS® **Rx Only**
(insulin glargine [rDNA origin] injection) solution for subcutaneous injection

Brief Summary of Prescribing Information

1. INDICATIONS AND USAGE

LANTUS is indicated to improve glycemic control in adults and children with type 1 diabetes mellitus and in adults with type 2 diabetes mellitus.

Important Limitations of Use:

- LANTUS is not recommended for the treatment of diabetic ketoacidosis. Intravenous short-acting insulin is the preferred treatment for this condition.

2. DOSAGE AND ADMINISTRATION

2.1 Dosing

LANTUS is a recombinant human insulin analog for once daily subcutaneous administration with potency that is approximately the same as the potency of human insulin. LANTUS exhibits a relatively constant glucose-lowering profile over 24 hours that permits once-daily dosing.

LANTUS may be administered at any time during the day. LANTUS should be administered subcutaneously once a day at the same time every day. The dose of LANTUS must be individualized based on clinical response. Blood glucose monitoring is essential in all patients receiving insulin therapy.

Patients adjusting the amount or timing of dosing with LANTUS, should only do so under medical supervision with appropriate glucose monitoring *[see Warnings and Precautions (5.1)*.]

In patients with type 1 diabetes, LANTUS must be used in regimens with short-acting insulin.

The intended duration of activity of LANTUS is dependent on injection into subcutaneous tissue *[see Clinical pharmacology (12.2) in the full prescribing information]*. LANTUS should not be administered intravenously or via an insulin pump. Intravenous administration of the usual subcutaneous dose could result in severe hypoglycemia *[see Warnings and Precautions (5.3)]*.

As with all insulins, injection sites should be rotated within the same region (abdomen, thigh, or deltoid) from one injection to the next to reduce the risk of lipodystrophy *[See Adverse Reactions (6.1)]*.

In clinical studies, there was no clinically relevant difference in insulin glargine absorption after abdominal, deltoid, or thigh subcutaneous administration. As for all insulins, the rate of absorption, and consequently the onset and duration of action, may be affected by exercise and other variables, such as stress, intercurrent illness, or changes in co-administered drugs or meal patterns.

2.2 Initiation of LANTUS therapy

The recommended starting dose of LANTUS in patients with type 1 diabetes should be approximately one-third of the total daily insulin requirements. Short-acting, premeal insulin should be used to satisfy the remainder of the daily insulin requirements.

The recommended starting dose of LANTUS in patients with type 2 diabetes who are not currently treated with insulin is 10 units (or 0.2 Units/kg) once daily, which should subsequently be adjusted to the patient's needs.

The dose of LANTUS should be adjusted according to blood glucose measurements. The dosage of LANTUS should be individualized under the supervision of a healthcare provider in accordance with the needs of the patient.

2.3 Converting to LANTUS from other insulin therapies

If changing from a treatment regimen with an intermediate- or long-acting insulin to a regimen with LANTUS, the amount and timing of shorter-acting insulins and doses of any oral anti-diabetic drugs may need to be adjusted.

- If transferring patients from once-daily NPH insulin to once-daily LANTUS, the recommended initial LANTUS dose is the same as the dose of NPH that is being discontinued.
- If transferring patients from twice-daily NPH insulin to once-daily LANTUS, the recommended initial LANTUS dose is 80% of the total NPH dose that is being discontinued. This dose reduction will lower the likelihood of hypoglycemia [*see Warnings and Precautions (5.3)]*.

4. CONTRAINDICATIONS

LANTUS is contraindicated in patients with hypersensitivity to LANTUS or one of its excipients.

5. WARNINGS AND PRECAUTIONS

5.1 Dosage adjustment and monitoring

Glucose monitoring is essential for all patients receiving insulin therapy. Changes to an insulin regimen should be made cautiously and only under medical supervision.

Changes in insulin strength, manufacturer, type, or method of administration may result in the need for a change in insulin dose or an adjustment in concomitant oral anti-diabetic treatment.

As with all insulin preparations, the time course of action for LANTUS may vary in different individuals or at different times in the same individual and is dependent on many conditions, including the local blood supply, local temperature, and physical activity.

5.2 Administration

Do not administer LANTUS intravenously or via an insulin pump. The intended duration of activity of LANTUS is dependent on injection into subcutaneous tissue

Intravenous administration of the usual subcutaneous dose could result in severe hypoglycemia *[see Warnings and Precautions (5.3)]*.

Do not dilute or mix LANTUS with any other insulin or solution. If LANTUS is diluted or mixed, the solution may become cloudy, and the pharmacokinetic or pharmacodynamic profile (e.g., onset of action, time to peak effect) of LANTUS and the mixed insulin may be altered in an unpredictable manner. When LANTUS and regular human insulin were mixed immediately before injection in dogs, a delayed onset of action and a delayed time to maximum effect for regular human insulin was observed. The total bioavailability of the mixture was also slightly decreased compared to separate injections of LANTUS and regular human insulin. The relevance of these observations in dogs to humans is unknown.

Do not share disposable or reusable insulin devices or needles between patients, because doing so carries a risk for transmission of blood-borne pathogens.

5.3 Hypoglycemia

Hypoglycemia is the most common adverse reaction of insulin, including LANTUS. The risk of hypoglycemia increases with intensive glycemic control. Patients must be educated to recognize and manage hypoglycemia. Severe hypoglycemia can lead to unconsciousness or convulsions and may result in temporary or permanent impairment of brain function or death. Severe hypoglycemia requiring the assistance of another person or parenteral glucose infusion or glucagon administration has been observed in clinical trials with insulin, including trials with LANTUS.

The timing of hypoglycemia usually reflects the time-action profile of the administered insulin formulations. Other factors such as changes in food intake (e.g., amount of food or timing of meals), exercise, and concomitant medications may also alter the risk of hypoglycemia [*See Drug Interactions (7)*].

The prolonged effect of subcutaneous LANTUS may delay recovery from hypoglycemia. Patients being switched from twice daily NPH insulin to once-daily LANTUS should have their initial LANTUS dose reduced by 20% from the previous total daily NPH dose to reduce the risk of hypoglycemia *[see Dosage and Administration (2.3)]*.

As with all insulins, use caution in patients with hypoglycemia unawareness and in patients who may be predisposed to hypoglycemia (e.g., the pediatric population and patients who fast or have erratic food intake). The patient's ability to concentrate and react may be impaired as a result of hypoglycemia. This may present a risk in situations where these abilities are especially important, such as driving or operating other machinery.

Early warning symptoms of hypoglycemia may be different or less pronounced under certain conditions, such as longstanding diabetes, diabetic neuropathy, use of medications such as beta-blockers, or intensified glycemic control. These situations may result in severe hypoglycemia (and, possibly, loss of consciousness) prior to the patient's awareness of hypoglycemia.

5.4 Hypersensitivity and allergic reactions

Severe, life-threatening, generalized allergy, including anaphylaxis, can occur with insulin products, including LANTUS.

5.5 Renal impairment

Due to its long duration of action, Lantus is not recommended during periods of rapidly declining renal function because of the risk for prolonged hypoglycemia.

Although studies have not been performed in patients with diabetes and renal impairment, a reduction in the LANTUS dose may be required in patients with renal impairment because of reduced insulin metabolism, similar to observations found with other insulins. *[See Clinical Pharmacology (12.3) in the full prescribing information]*.

5.6 Hepatic impairment

Due to its long duration of action, Lantus is not recommended during periods of rapidly declining hepatic function because of the risk for prolonged hypoglycemia.

Although studies have not been performed in patients with diabetes and hepatic impairment, a reduction in the LANTUS dose may be required in patients with hepatic impairment because of reduced capacity for gluconeogenesis and reduced insulin metabolism, similar to observations found with other insulins. *[See Clinical Pharmacology (12.3) in the full prescribing information]*.

5.7 Drug interactions

Some medications may alter insulin requirements and subsequently increase the risk for hypoglycemia or hyperglycemia *[See Drug Interactions (7)]*.

6. ADVERSE REACTIONS

The following adverse reactions are discussed elsewhere:

- Hypoglycemia *[See Warnings and Precautions (5.3)]*
- Hypersensitivity and allergic reactions *[See Warnings and Precautions (5.4)]*

6.1 Clinical trial experience

Because clinical trials are conducted under widely varying designs, the adverse reaction rates reported in one clinical trial may not be easily compared to those rates reported in another clinical trial, and may not reflect the rates actually observed in clinical practice.

The frequencies of treatment-emergent adverse events during LANTUS clinical trials in patients with type 1 diabetes mellitus and type 2 diabetes mellitus are listed in the tables below.

Table 1: Treatment –emergent adverse events in pooled clinical trials up to 28 weeks duration in adults with type 1 diabetes (adverse events with frequency ≥ 5%)

	LANTUS, % (n=1257)	NPH, % (n=1070)
Upper respiratory tract infection	22.4	23.1
Infection *	9.4	10.3
Accidental injury	5.7	6.4
Headache	5.5	4.7

*Body System not Specified

Table 2: Treatment –emergent adverse events in pooled clinical trials up to 1 year duration in adults with type 2 diabetes (adverse events with frequency ≥ 5%)

	LANTUS, % (n=849)	NPH, % (n=714)
Upper respiratory tract infection	11.4	13.3
Infection*	10.4	11.6
Retinal vascular disorder	5.8	7.4

*Body System not Specified

Table 3: Treatment –emergent adverse events in a 5-year trial of adults with type 2 diabetes (adverse events with frequency ≥ 10%)

	LANTUS, % (n=514)	NPH, % (n=503)
Upper respiratory tract infection	29.0	33.6
Edema peripheral	20.0	22.7
Hypertension	19.6	18.9
Influenza	18.7	19.5
Sinusitis	18.5	17.9
Cataract	18.1	15.9
Bronchitis	15.2	14.1
Arthralgia	14.2	16.1
Pain in extremity	13.0	13.1
Back pain	12.8	12.3
Cough	12.1	7.4
Urinary tract infection	10.7	10.1
Diarrhea	10.7	10.3
Depression	10.5	9.7
Headache	10.3	9.3

Table 4: Treatment –emergent adverse events in a 28-week clinical trial of children and adolescents with type 1 diabetes (adverse events with frequency ≥ 5%)

	LANTUS, % (n=174)	NPH, % (n=175)
Infection*	13.8	17.7
Upper respiratory tract infection	13.8	16.0
Pharyngitis	7.5	8.6
Rhinitis	5.2	5.1

*Body System not Specified

- *Severe Hypoglycemia*

Hypoglycemia is the most commonly observed adverse reaction in patients using insulin, including LANTUS *[See Warnings and Precautions (5.3)]*. Tables 5 and 6 summarize the incidence of severe hypoglycemia in the LANTUS individual clinical trials. Severe symptomatic hypoglycemia was defined as an event with symptoms consistent with hypoglycemia requiring the assistance of another person and associated with either a blood glucose below 50 mg/dL (≤56 mg/dL in the 5-year trial) or prompt recovery after oral carbohydrate, intravenous glucose or glucagon administration.

The rates of severe symptomatic hypoglycemia in the LANTUS clinical trials (see Section 14 for a description of the study designs) were comparable for all treatment regimens (see Tables 5 and 6). In the pediatric phase 3 clinical trial, children and adolescents with type 1 diabetes had a higher incidence of severe symptomatic hypoglycemia in the two treatment groups compared to the adult trials with type 1 diabetes. (see Table 5) *[See Clinical Studies (14) in the full prescribing information]*.

Table 5: Severe Symptomatic Hypoglycemia in Patients with Type 1 Diabetes

	Study A Type 1 Diabetes Adults 28 weeks In combination with regular insulin		Study B Type 1 Diabetes Adults 28 weeks In combination with regular insulin		Study C Type 1 Diabetes Adults 16 weeks In combination with insulin lispro		Study D Type 1 Diabetes Pediatrics 26 weeks In combination with regular insulin	
	LANTUS	NPH	LANTUS	NPH	LANTUS	NPH	LANTUS	NPH
Percent of patients (n/total N)	10.6 (31/292)	15.0 (44/293)	8.7 (23/264)	10.4 (28/270)	6.5 (20/310)	5.2 (16/309)	23.0 (40/174)	28.6 (50/175)

Table 6: Severe Symptomatic Hypoglycemia in Patients with Type 2 Diabetes

	Study E Type 2 Diabetes Adults 52 weeks In combination with oral agents		Study F Type 2 Diabetes Adults 28 weeks In combination with regular insulin		Study G Type 2 Diabetes Adults 5 years In combination with regular insulin	
	LANTUS	NPH	LANTUS	NPH	LANTUS	NPH
Percent of patients (n/total N)	1.7 (5/289)	1.1 (3/281)	0.4 (1/259)	2.3 (6/259)	7.8 (40/513)	11.9 (60/504)

- *Retinopathy*

Retinopathy was evaluated in the LANTUS clinical studies by analysis of reported retinal adverse events and fundus photography. The numbers of retinal adverse events reported for LANTUS and NPH insulin treatment groups were similar for patients with type 1 and type 2 diabetes.

LANTUS was compared to NPH insulin in a 5-year randomized clinical trial that evaluated the progression of retinopathy as assessed with fundus photography using a grading protocol derived from the Early Treatment Diabetic Retinopathy Scale (ETDRS). Patients had type 2 diabetes (mean age 55 yrs) with no (86%) or mild (14%) retinopathy at baseline. Mean baseline HbA1c was 8.4%. The primary outcome was progression by 3 or more steps on the ETDRS scale at study endpoint. Patients with pre-specified post-baseline eye procedures (pan-retinal photocoagulation for proliferative or severe nonproliferative diabetic retinopathy, local photocoagulation for new vessels, and vitrectomy for diabetic retinopathy) were also considered as 3-step progressors regardless of actual change in ETDRS score from baseline. Retinopathy graders were blinded to treatment group assignment. The results for the primary endpoint are shown in Table 7 for both the per-protocol and Intent-to-Treat populations, and indicate similarity of Lantus to NPH in the progression of diabetic retinopathy as assessed by this outcome.

Table 7. Number (%) of patients with 3 or more step progression on ETDRS scale at endpoint

	Lantus (%)	NPH (%)	Difference*,† (SE)	95% CI for difference
Per-protocol	53/374 (14.2%)	57/363 (15.7%)	-2.0% (2.6%)	-7.0% to +3.1%
Intent-to-Treat	63/502 (12.5%)	71/487 (14.6%)	- 2.1% (2.1%)	-6.3% to +2.1%

*Difference = Lantus – NPH

†using a generalized linear model (SAS GENMOD) with treatment and baseline HbA1c strata (cutoff 9.0%) as the classified independent variables, and with binomial distribution and identity link function

- *Insulin initiation and intensification of glucose control*

Intensification or rapid improvement in glucose control has been associated with a transitory, reversible ophthalmologic refraction disorder, worsening of diabetic retinopathy, and acute painful peripheral neuropathy. However, long-term glycemic control decreases the risk of diabetic retinopathy and neuropathy.

- *Lipodystrophy*

Long-term use of insulin, including LANTUS, can cause lipodystrophy at the site of repeated insulin injections. Lipodystrophy includes lipohypertrophy (thickening of adipose tissue) and lipoatrophy (thinning of adipose tissue), and may affect insulin absorption. Rotate insulin injection or infusion sites within the same region to reduce the risk of lipodystrophy. *[See Dosage and Administration (2.1)]*.

- *Weight gain*

Weight gain can occur with insulin therapy, including LANTUS, and has been attributed to the anabolic effects of insulin and the decrease in glucosuria.

- *Peripheral Edema*

Insulin, including LANTUS, may cause sodium retention and edema, particularly if previously poor metabolic control is improved by intensified insulin therapy.

- *Allergic Reactions*

Local Allergy

As with any insulin therapy, patients taking LANTUS may experience injection site reactions, including redness, pain, itching, urticaria, edema, and inflammation. In clinical studies in adult patients, there was a higher incidence of treatment-emergent injection site pain in LANTUS-treated patients (2.7%) compared to NPH insulin-treated patients (0.7%). The reports of pain at the injection site did not result in discontinuation of therapy.

Rotation of the injection site within a given area from one injection to the next may help to reduce or prevent these reactions. In some instances, these reactions may be related to factors other than insulin, such as irritants in a skin cleansing agent or poor injection technique. Most minor reactions to insulin usually resolve in a few days to a few weeks.

Systemic Allergy

Severe, life-threatening, generalized allergy, including anaphylaxis, generalized skin reactions, angioedema, bronchospasm, hypotension, and shock may occur with any insulin, including LANTUS and may be life threatening.

- *Antibody production*

All insulin products can elicit the formation of insulin antibodies. The presence of such insulin antibodies may increase or decrease the efficacy of insulin and may require adjustment of the insulin dose. In phase 3 clinical trials of LANTUS, increases in titers of antibodies to insulin were observed in NPH insulin and insulin glargine treatment groups with similar incidences.

6.2 Postmarketing experience

The following adverse reactions have been identified during post-approval use of LANTUS.

Because these reactions are reported voluntarily from a population of uncertain size, it is not always possible to estimate reliably their frequency or establish a causal relationship to drug exposure.

Medication errors have been reported in which other insulins, particularly short-acting insulins, have been accidentally administered instead of LANTUS *[See Patient Counseling Information (17) in the full prescribing information*]. To avoid medication errors between LANTUS and other insulins, patients should be instructed to always verify the insulin label before each injection.

7. DRUG INTERACTIONS

A number of drugs affect glucose metabolism and may require insulin dose adjustment and particularly close monitoring.

The following are examples of drugs that may increase the blood-glucose-lowering effect of insulins including LANTUS and, therefore, increase the susceptibility to hypoglycemia: oral anti-diabetic products, pramlintide, angiotensin converting enzyme (ACE) inhibitors, disopyramide, fibrates, fluoxetine, monoamine oxidase inhibitors, propoxyphene, pentoxifylline, salicylates, somatostatin analogs, and sulfonamide antibiotics.

The following are examples of drugs that may reduce the blood-glucose-lowering effect of insulins including LANTUS: corticosteroids, niacin, danazol, diuretics, sympathomimetic agents (e.g., epinephrine, albuterol, terbutaline), glucagon, isoniazid, phenothiazine derivatives, somatropin, thyroid hormones, estrogens, progestogens (e.g., in oral contraceptives), protease inhibitors and atypical antipsychotic medications (e.g. olanzapine and clozapine).

Beta-blockers, clonidine, lithium salts, and alcohol may either potentiate or weaken the blood-glucose-lowering effect of insulin. Pentamidine may cause hypoglycemia, which may sometimes be followed by hyperglycemia.

The signs of hypoglycemia may be reduced or absent in patients taking sympatholytic drugs such as beta-blockers, clonidine, guanethidine, and reserpine.

8. USE IN SPECIFIC POPULATIONS

8.1 Pregnancy

Pregnancy Category C: Subcutaneous reproduction and teratology studies have been performed with insulin glargine and regular human insulin in rats and Himalayan rabbits. Insulin glargine was given to female rats before mating, during mating, and throughout pregnancy at doses up to 0.36 mg/kg/day, which is approximately 7 times the recommended human subcutaneous starting dose of 10 Units/day (0.008 mg/kg/day), based on mg/m^2. In rabbits, doses of 0.072 mg/kg/day, which is approximately 2 times the recommended human subcutaneous starting dose of 10 Units/day (0.008 mg/kg/day), based on mg/m^2, were administered during organogenesis. The effects of insulin glargine did not generally differ from those observed with regular human insulin in rats or rabbits. However, in rabbits, five fetuses from two litters of the high-dose group exhibited dilation of the cerebral ventricles. Fertility and early embryonic development appeared normal.

There are no well-controlled clinical studies of the use of LANTUS in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. It is essential for patients with diabetes or a history of gestational diabetes to maintain good metabolic control before conception and throughout pregnancy. Insulin requirements may decrease during the first trimester, generally increase during the second and third trimesters, and rapidly decline after delivery. Careful monitoring of glucose control is essential in these patients.

8.3 Nursing Mothers

It is unknown whether insulin glargine is excreted in human milk. Because many drugs, including human insulin, are excreted in human milk, caution should be exercised when LANTUS is administered to a nursing woman. Use of LANTUS is compatible with breastfeeding, but women with diabetes who are lactating may require adjustments of their insulin doses.

8.4 Pediatric Use

The safety and effectiveness of subcutaneous injections of LANTUS have been established in pediatric patients (age 6 to 15 years) with type 1 diabetes *[see Clinical Studies (14) in the full prescribing information]*. LANTUS has not been studied in pediatric patients younger than 6 years of age with type 1 diabetes. LANTUS has not been studied in pediatric patients with type 2 diabetes.

Based on the results of a study in pediatric patients, the dose recommendation when switching to LANTUS is the same as that described for adults *[see Dosage and Administration (2.3)* and *Clinical Studies (14) in the full prescribing information]*. As in adults, the dosage of LANTUS must be individualized in pediatric patients based on metabolic needs and frequent monitoring of blood glucose.

8.5 Geriatric Use

In controlled clinical studies comparing LANTUS to NPH insulin, 593 of 3890 patients (15%) with type 1 and type 2 diabetes were ≥65 years of age and 80 (2%) patients were ≥75 years of age. The only difference in safety or effectiveness in the subpopulation of patients ≥65 years of age compared to the entire study population was a higher incidence of cardiovascular events typically seen in an older population in both LANTUS and NPH insulin-treated patients.

Nevertheless, caution should be exercised when LANTUS is administered to geriatric patients. In elderly patients with diabetes, the initial dosing, dose increments, and maintenance dosage should be conservative to avoid hypoglycemic reactions. Hypoglycemia may be difficult to recognize in the elderly *[See Warnings and Precautions (5.3)]*.

10. OVERDOSAGE

An excess of insulin relative to food intake, energy expenditure, or both may lead to severe and sometimes prolonged and life-threatening hypoglycemia. Mild episodes of hypoglycemia can usually be treated with oral carbohydrates. Adjustments in drug dosage, meal patterns, or exercise may be needed.

More severe episodes of hypoglycemia with coma, seizure, or neurologic impairment may be treated with intramuscular/subcutaneous glucagon or concentrated intravenous glucose. After apparent clinical recovery from hypoglycemia, continued observation and additional carbohydrate intake may be necessary to avoid recurrence of hypoglycemia.

Rev. April 2010
sanofi-aventis U.S. LLC
Bridgewater, NJ 08807
©2010 sanofi-aventis U.S. LLC

GLA-BPLR-SA-APR10

HOW TO CONTACT US

Call us at the numbers listed below, or send a fax to **913-906-6080**. Use the list below to identify the person who can best help you:

Advertising

- Display advertising
  Dan Gowan, advertising sales director/associate publisher: 201-288-4400; 201-288-4914 (fax); dgowan@aafp.org
- Classified advertising
  Russell Johns Associates, LLC: 800-237-7027; 727-445-9380 (fax); fpm@russelljohns.com

Article ideas

Robert L. Edsall, editor-in-chief: 800-274-2237, ext. 5110; bedsall@aafp.org

Articles, letters, "Coding & Documentation," "Practice Pearls"

fpmedit@aafp.org

Change of address

- Print subscribers
  http://www.aafp.org/updatecontactinfo or call the AAFP Contact Center: 800-274-2237
- Digital edition recipients
  Refer to the e-mail message you receive with each issue.

Delivery problems, back issues, subscriptions

AAFP Contact Center: 800-274-2237; contactcenter@aafp.org. To subscribe, visit http://www.aafp.org/fpm/subscribe. One-year subscription (six issues) for AAFP members is $30 (U.S.), $42 (Canada) and $52 (foreign). Nonmember medical students, residents, allied health care professionals and medical office management staff, $43 (U.S.), $55 (Canada) and $65 (foreign). Nonmember physicians and other individuals, $58 (U.S.), $70 (Canada) and $80 (foreign). Institutions, $80 (U.S.), $92 (Canada) and $102 (foreign). Payment must be accompanied by identification of profession. Remit in U.S. dollars, drawn on a U.S. bank. Ask about discounted rates for *American Family Physician* when you purchase a combined subscription with *FPM*. Back issues are $15 per copy for six or fewer issues and $10 per copy for seven or more issues plus shipping for countries outside the U.S.

FPM Family Practice Management®

Permission to reuse material from *FPM*

- Academic use, general photocopying, or electronic use
  Go online to http://www.copyright.com and enter ISSN 1069-5648 in the search box, or contact the Copyright Clearance Center: 978-750-8400; 978-646-8700 (fax); info@copyright.com
- Bulk reprints or ePrints
  Beth Ann Rocheleau, Sheridan Reprints: 803-359-4578; brocheleau@rockwaterinc.com
- Other requests
  AAFP intellectual property coordinator: copyrights@aafp.org

We want to hear from you!

Send your comments, questions, ideas and suggestions to fpmedit@aafp.org.

Conference on Practice Improvement

Redesign your practice. Improve patient care. Sustain your changes.



December 1-4, 2011
Newport Beach, CA

To register, visit www.stfm.org/cpi or www.aafp.org/cpi

AMERICAN ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

SOCIETY OF TEACHERS OF FAMILY MEDICINE

The RUC Under Fire

Time may be running out for the group that helps divide the Medicare pie.

A few years ago, I suspect, most physicians were at best vaguely aware of the existence of the Relative Value Update Committee (RUC). Now, though, I hope most physicians know that this AMA committee of 29 physicians who spend hours arguing over tenths and hundredths of relative value units (RVUs) assigned to CPT codes plays a huge role in determining how much physicians are paid. (See "What Every Physician Should Know About the RUC," http://www.aafp.org/fpm/2008/0200/p36.html.) With the current Medicare conversion factor of $33.9764 per RVU, those tenths of RVUs are worth $3.40 apiece. Multiply the number of office visit codes you submit in a year by $3.40 to see how much even one tenth can mean to you.

For some time, the AAFP and other primary care physician organizations have contended that the RUC process is biased toward procedural specialties, thus perpetuating and worsening the income gap between specialties and contributing to the primary care shortage. Some have urged the primary care specialties to quit the RUC in protest, and while the AAFP has declined so far, it did send the RUC a letter in June urging more primary care representation and more seats for stakeholders from outside the house of medicine (http://bit.ly/RUCLetter); it also formed a task force to explore alternatives to the RUC.

Now, a group of Georgia physicians is suing the Centers for Medicare & Medicaid Services (CMS) alleging that CMS has harmed them by its reliance on the RUC and asking for an injunction to interrupt the CMS/RUC relationship until the committee can be brought into compliance with the Federal Advisory Committee Act, which requires balanced representation and transparent proceedings, among other things (http://bit.ly/RUCSuit).

Given the way the RUC allegedly overvalues procedural services, thereby encouraging continual growth in the volume of those services and driving up health care costs, I have to wonder if the fumbling efforts of Washington to reduce the deficit (or to reduce the annual increase in the deficit) won't bring the whole RUC process into question. Accountable care organizations (ACOs; see page 17) might offer a fairer process for dividing the pie. Of course, the state of the budget and the mood of Congress make it likely that there won't be as much pie to go around, so the interspecialty battles over what is available may simply reappear in the internal politics of ACOs. *Plus ça change* ...

Robert Edsall, Editor-in-Chief
fpmedit@aafp.org

Family Practice Management®

EDITOR-IN-CHIEF
Robert L. Edsall

MANAGING EDITOR
Leigh Ann Backer

SENIOR EDITOR
Brandi White

ASSOCIATE EDITOR
Lynn Hofeldt

ART DIRECTOR
Christine Schneider

BOARD OF EDITORS
Kenneth G. Adler, MD, MMM, Tucson, Ariz.
Kenny Lin, MD, Washington, D.C.
David A. Lynch, MD, Bellingham, Wash.
Karl Singer, MD, Exeter, N.H.
Christine A. Sinsky, MD, Dubuque, Iowa
William D. Soper, MD, MBA, Kansas City, Mo.

CONTRIBUTING EDITORS
Alice G. Gosfield, JD; Cindy Hughes, CPC; David C. Kibbe, MD, MBA; Kent J. Moore

PUBLISHER
Stephanie Hanaway

ADMINISTRATIVE ASSISTANT
Marilyn Harvey

EDITORIAL DIRECTOR
Robert L. Edsall

EXECUTIVE VICE PRESIDENT
Douglas E. Henley, MD

VICE PRESIDENT FOR PUBLICATIONS AND STRATEGIC PARTNERSHIPS
Craig Doane

INTELLECTUAL PROPERTY COORDINATOR
Melissa Lavenbarg

CIRCULATION DIRECTOR
Cathy L. Donahue

ASSISTANT CIRCULATION MANAGER
Carrie Burkin

CIRCULATION COORDINATOR
Rebecca M. Fuller

ASSOCIATE PUBLISHER/MARKETING DIRECTOR
Linda G. Doggett

ADVERTISING BUSINESS MANAGER
Brian W. Arbuckle

SENIOR PROJECT COORDINATOR
Amy Swift

PRODUCTION DIRECTOR
Bret Taylor

PRODUCTION GRAPHICS MANAGER
Stacey Herrmann

GRAPHIC ASSOCIATES
Bryan Colley; Debra Rodriguez

ADVERTISING COORDINATOR
Linda A. Porter

WEB TECHNICIAN
Stephanie Chapel

ASSOCIATE PUBLISHER/ADVERTISING SALES DIRECTOR
Dan Gowan

DIRECTOR OF ADVERTISING SALES
John Molluso

NATIONAL ACCOUNT MANAGER
Mickey Cotter

When I grow up I want to fill out an endless mountain of paperwork

We know this isn't why you went into medicine

Amazing Charts is the intuitive, user-friendly EHR that is affordable and easy to learn.

- ✓ **Affordable –** $1,995 per provider then $995/year thereafter
- ✓ **Usable –** Rated #1 for ease of use and user satisfaction in multiple studies*
- ✓ **Risk-free to try –** Free to download and use for three months
- ✓ **No hidden costs –** Includes ePrescribing, training, software maintenance, and technical support

ONC-ATCB CERTIFIED Supporting Meaningful Use 2011-2012 Complete EHR

Amazing Charts v6
CC-1112-855220-1

Visit www.amazingcharts.com or call 866.382.5932

amazingcharts

Electronic Health Records | ePrescribing | Scheduling | Intraoffice Messaging | Integrated Billing

*__AAFP__: In the ongoing study by the Center for Health IT at the AAFP, Amazing Charts is the highest rated EHR beating more than 90 other EHR systems for quality, price, support, ease of use, and impact on productivity (data as of 10/09, www.centerforhit.org).

*__Medscape__: In the Medscape Exclusive Reader's Survey of over 3,700 EHR users, Amazing Charts was the highest rated EHR (www.medscape.com/viewarticle/709856).

*__Family Practice Management__: In the 2009 EHR User Satisfaction Survey: Responses From 2,012 Family Physicians, Amazing Charts received the #1 rating of any EHR for ease and intuitiveness, ease of documentation, worth the expense and user satisfaction (FPM, www.aafp.org/fpm, Nov/Dec 2009).

The reporting of these results does not constitute an endorsement by the study publishers.

FPM and payment reform

I read with interest the testimony of AAFP President Roland A. Goertz, MD, MBA, to the health subcommittee of the U.S. House of Representatives Energy and Commerce Committee on May 5, 2011. I thought his testimony about alternatives to the sustainable growth rate formula – a blended payment model in particular – was informed and well organized. (Dr. Goertz's testimony is available as a PDF download at http://bit.ly/qpfrD1 or as part of the *AAFP News Now* story at http://bit.ly/pZELJO.)

I have been a member of the AAFP for many years and was among the first to take the board certification examination of the American Board of Family Practice (now the ABFM) in 1970. I now work as a clinical director at the Utah State Developmental Center and feel fortunate to be actively involved in the practice of medicine after all these years.

In April 1994, *Family Practice Management* published the article "Family Physicians Should be Paid for Managing," which I wrote with help from Robert L. Edsall, editor in chief of *FPM*. (Read the article at http://www.aafp.org/fpm/2011/0900/fpm20110900p12-rt1.pdf.)

After reading Dr. Goertz's testimony and seeing that he referenced several articles, I was disappointed that our article was not among them. I realize our article was written some time ago, but I firmly believe it contains the essence of Dr. Goertz's testimony as far as his recommendation for payment reform is concerned.

Joseph V. Cook, MD
Salt Lake City

Finding the right balance of 99214s

Your recent article "Five Common Coding Mistakes That Are Costing You" [March/April 2011, http://www.aafp.org/fpm/2011/0300/p31.html] highlighted that family physicians are often failing to code potential 99214s. However, at the same time, we are getting notices from Medicare stating that physicians should watch their ratios of 99214s to avoid audits. This is a tough balance. Can you tell me what percentage of our office visits can be 99214s without raising a red flag? We have an EHR and try to code very responsibly and accurately, but the idea of a government audit is scaring us.

Peter G. Gosselink, MD
Marble Falls, Texas

Author's response:
Medicare has not established a percentage of 99214 visits that would automatically trigger an audit. Like other payers, Medicare contractors expect the distribution of evaluation and management (E/M) codes to resemble a bell-shaped curve. Payers recognize there may be some left or right shift to the curve based on specialty, patient population and other practice-specific factors. They compare an individual physician's coding patterns to those of other physicians in the same specialty and geographic area. Those physicians who are outside the norm may be subject to a review.

The coding frequency comparison spreadsheet referenced in the article you mention (see http://www.aafp.org/fpm/2007/0400/fpm20070400p39-rt1.xls) allows you to compare your personal coding pattern to those of other family physicians in much the same way that Medicare would, using benchmark data from the Centers for Medicare & Medicaid Services. Your regional Medicare contractor may use its own distribution percentages for benchmarking; you may want to check to see if these are available.

Keep in mind that Medicare data may not be representative of services provided to a younger population. For another resource to assist in this analysis, see "How to Analyze Your E/M Coding Profile," *FPM*, April 2007, available at http://www.aafp.org/fpm/2007/0400/p39.html.

Emily Hill, PA-C
Wilmington, N.C.

Improving clinical care with *FPM*

I was unable to answer CME quiz question No. 12 for the May/June 2011 issue of *FPM*, as it asked for my rating of the issue as a vehicle in the nonclinical aspects of practice. I felt that this issue – with a special focus on chronic disease care – was utterly fantastic as a vehicle to improve *clinical* care.

Larry E. Jennings, MD
Jackson, Mich.

FPM

WE WANT TO HEAR FROM YOU

Send your comments to *FPM* Letters Editor by e-mail, **fpmedit@aafp.org**; by mail, *Family Practice Management*, 11400 Tomahawk Creek Parkway, Leawood, KS 66211-2680; or by fax, 913-906-6010. Include your address, daytime phone number and fax number. Submission of a letter will be construed as granting AAFP permission to publish the letter in any of its publications in any form. We cannot respond to all letters we receive. Those chosen for publication will be edited for length and style.

#1-prescribed antihistamine[1,*]— available OTC

Powerful...Non-sedating...

Recommend Allegra®

and Go for Both!

Allegra® combines fast,† non-sedating, 24-hour‡ indoor/outdoor allergy symptom relief

Recommend Allegra®—
All 7 formulations available without a prescription, including Children's Allegra® and Allegra-D®

Visit **Allegra.com/samples** to request samples of 180-mg tablets.

*** Among branded oral antihistamines from 1/2010 through 12/2010.**
† Refers only to adult formulations. Starts working at hour one. Applies to first dose only.
‡ 24-hour tablet 1x per day or 12-hour tablet 2x per day.

Stops symptoms, not patients

4051A-1
© 2011 Chattem, Inc.

Reference: 1. IMS Health. IMS National Prescription Audit™. 12/2010.

The EHR Incentive Program: Consider Waiting for Next Year

David C. Kibbe, MD MBA

It may get easier and cheaper to earn the incentive.

[Editor's note: Because of its timeliness, this article was published online ahead of print on July 7, 2011; it is published here in its original form.]

We're more than halfway through 2011 and just a few months from the last effective date a physician could begin meaningful use of certified electronic health record (EHR) technology and still qualify for a Medicare EHR incentive payment in 2011, given that 90 consecutive days of meaningful use are required to qualify. The handy timer provided by the AAFP Center for Health IT (http://bit.ly/EHRtimer) tells me I have 89 days, 4 hours and 5 minutes as I write this. If you don't have a certified EHR yet, that's not much time.

So where do we stand?

- More than 56,000 providers had registered for the Medicare or Medicaid EHR incentive programs through May 2011. That was the figure given by officials from the Centers for Medicare & Medicaid Services (CMS) during a health data management web seminar on June 21.
- CMS announced on May 19 that more than 300 physicians, hospitals and other eligible EHR users qualified for the first stage of the Medicare EHR incentive program and received payments totaling about $75 million.
- As of mid-June, 17 states had launched their Medicaid EHR incentive programs, with 11 of them already making payments totaling $114.4 million to qualifying physicians and hospitals.

These are paltry numbers compared with the 600,000 or so physicians who could qualify for incentives and the $19 billion that Congress has allocated for them. Although no one at the Office of the National Coordinator (ONC) will comment on what their expectations were for physician participation in the first year, the numbers from 2011 are bound to disappoint. This money, after all, was part of the economic stimulus meant to be spent to create jobs, which it has done only at the margins.

If you begin with 90 days of meaningful use next year, you can still qualify for the full incentive amount.

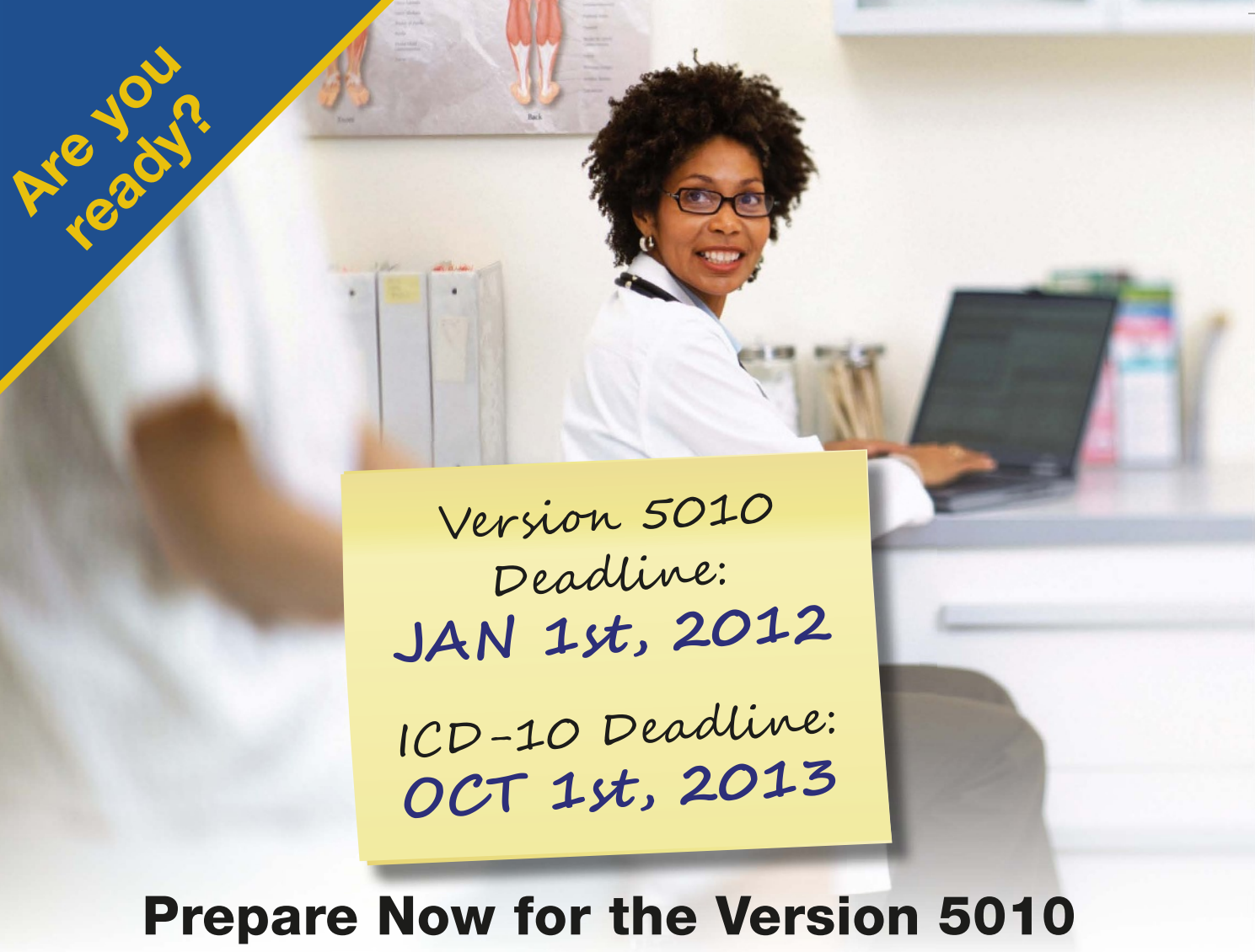
Here's another number – one that can help us understand at least in part why participation in the EHR incentive programs is so low: As I write this, I count 412 outpatient EHRs on the Center for Health IT's list of

About the Author

Dr. Kibbe is a senior adviser to the AAFP's Center for Health IT (CHIT), in Leawood, Kan., chair of the ASTM International E31 Technical Committee on Healthcare Informatics, and principal of The Kibbe Group, LLC. Author disclosure: no relevant financial affiliations disclosed.

WHAT DO YOU THINK?

The views expressed in the "Opinion" section of *Family Practice Management* do not necessarily represent those of *FPM* or our publisher, the American Academy of Family Physicians. We recognize that your point of view may differ from the author's, and we encourage you to share it. Please send your comments to *FPM* at fpmedit@aafp.org or 11400 Tomahawk Creek Parkway, Leawood, Kansas 66211-2680.



Prepare Now for the Version 5010 and ICD-10 Transitions

The change to Version 5010 standards takes effect on January 1, 2012.
The change to ICD-10 codes takes effect on October 1, 2013.

In preparation for ICD-10, starting January 1, 2012, all practice management and other applicable software programs should feature the updated Version 5010 HIPAA transaction standards. Providers will need to use ICD-10 diagnosis and inpatient procedure codes starting on October 1, 2013.

Make sure your claims continue to get paid. Talk with your software vendor, clearinghouse, or billing service NOW, and work together to make sure you'll have what you need to be ready. A successful transition to Version 5010 and ICD-10 will be vital to transforming our nation's health care system.

Visit www.cms.gov/ICD10 to find out how CMS can help prepare you for a smooth transition to Version 5010 and ICD-10.

CMS CENTERS for MEDICARE & MEDICAID SERVICES ICD-10

Official CMS Industry Resources for the ICD-10 Transition
www.cms.gov/ICD10

products that have received modular or complete certification from the ONC (http://bit.ly/EHRCertList; AAFP members only). Four hundred twelve! That's about one newly certified EHR product for each doctor who has qualified for the incentives so far – and all of these products were certified in about a year. It's roughly 10 times the number of EHRs that the Certification Commission for Health Information Technology (CCHIT) certified between 2005 and 2009. That's a lot of EHR products.

Meanwhile, a relatively small number of legacy vendors account for 75 percent or more of the EHRs used at present and the great majority of meaningful-use-related new sales. They include EPIC, Allscripts, eClinicalWorks, PracticePartner, eMDs, athenaClinicals and Sage.

So this isn't quite a balanced market for EHR technology yet, is it? On the one hand, we have a small number of legacy client-server applications that are reportedly charging high prices to their customers to upgrade to the level of Meaningful Use Stage 1 and are apparently often unable to guarantee that they'll be able to deliver and install the software upgrades due to the high demand. And on the other hand, we have several hundred EHRs, most of them newly certified, most of which relatively few people have heard of and most used by only a handful of doctors.

Prudent physicians and health care organizations across the country are sitting out meaningful use for 2011. Here's why:

- Next year at this time, some of those newer EHRs may have proven themselves to be reliable and affordable, designed to meet meaningful use criteria, perhaps with platforms in the cloud; some will even run on the iPad.
- Next year at this time, the legacy vendors' prices for upgrades will probably have decreased as their demand tapers off in the face of new competition for price, features and ease of use.
- If you begin with 90 days of meaningful use next year, you can still qualify for the full incentive amount.
- And by next year, if the stars align, the ONC and CMS will have taken to heart the recommendations from many, including the AAFP, to simplify, streamline and stretch out the timeline for the processes involved with applying for, attaining and getting paid for the "meaningful use of certified EHR technology." FPM

Send comments to **fpmedit@aafp.org.**

Send unlimited secure clinical messages.

AAFP Physicians Direct is messaging made easy.

Share patient health data through a secure network.

AMERICAN ACADEMY OF FAMILY PHYSICIANS

Register today.

aafp.org/physiciansdirect

WHAT FAMILY PHYSICIANS NEED TO KNOW ABOUT

RON CHAN

Accountable care organizations could be the next big thing in health care delivery. Here's what you need to know – and what you need to do – now.

Julian D. Bobbitt, JD

Accountable care organizations (ACOs) are one of the most anticipated and, perhaps, most confusing developments in health care today. The Patient Protection and Affordable Care Act called for the creation of ACOs as a way to encourage physicians, hospitals and other health care providers to work across settings to coordinate and improve care for a defined population of patients and take part in any cost savings they achieve.

The health care reform law mandated that the Medicare ACO program (called the Medicare Shared Savings Program) be operational by January 2012 – an ambitious deadline given that the final rule governing Medicare ACOs has not yet been issued. The proposed rule, published March 31, 2011, was widely criticized by physician groups, including the AAFP and the AMA, as being too burdensome and forcing physicians to bear too much risk. Even the American Medical Group Association, which represents major multispecialty groups such as the Mayo Clinic and the Cleveland Clinic, those in prime position to form ACOs, warned that 93 percent of its members would not participate in the Medicare Shared Savings Program unless the rules changed substantially. In response, the Centers for Medicare & Medicaid Services (CMS) launched the Pioneer ACO program to offer already-integrated systems a streamlined method for participation. The final rule is expected this fall.

Although the final rule is important, it only governs ACOs that contract with Medicare. ACOs that want to contract with private payers are free to proceed without the government's rules – and they are doing just that. For example, Advocate Physician Partners in Illinois has signed its first ACO contract with Blue Cross Blue Shield of Illinois; Norton Healthcare in Kentucky has partnered with Humana to develop an ACO; Sharp Community Medical Group and Sharp Rees-Stealy Medical Centers have partnered with Anthem Blue Cross on an ACO pilot in San Diego; and Carilion Clinic in Roanoke, Va., has collaborated with Aetna to form an ACO, to name just a few. It is said that "necessity is the mother of inven-

ALTHOUGH MULTIPLE TYPES OF PROVIDERS CAN PARTICIPATE IN AN ACO, HIGH-PERFORMING PRIMARY CARE PHYSICIANS ARE ESSENTIAL.

tion." With the fiscal crisis so bad in many states, we are seeing ACO innovation at the state Medicaid level, as well.

"Whatever form ACOs eventually take, one thing is certain," according to Don Berwick, MD, CMS Administrator. "The era of fragmented care delivery should draw to a close."[1]

ACOs encourage providers to work across settings to coordinate and improve care for a defined population of patients.

What is an ACO?

At the most basic level, an ACO is an entity made up of health care providers who take responsibility for the health care needs of a defined population of patients, with the goals of improving care coordination, quality and the patient experience and reducing per capita costs. ACOs that achieve specific benchmarks related to these goals distribute any shared savings to the providers.

If an ACO meets defined performance goals, its providers receive a portion of any cost savings achieved.

The name "accountable care organization" suggests that an ACO is a particular type of organization; however, that is not the case. The NCQA's ACO criteria, for example, are "agnostic to organizational structure."[2] An ACO could be created by any of the following entities: independent physician practices (connected via an independent practice association or a virtual physician organization), a multispecialty group practice, a hospital (either with employed physicians or affiliated practices), an integrated delivery system or some combination of the above. Of course, more integrated entities, such as multispecialty group practices and integrated delivery systems, would likely have less work to do to develop the capabilities of an ACO and could assume greater risk at the outset than less integrated entities.

An ACO could be created by independent practices, a multispecialty group, a hospital, an integrated delivery system or some combination.

Although multiple types of providers can participate in an ACO, primary care physicians – particularly high-performing primary care physicians – are essential.[3] In fact, they are the only providers mandated for inclusion in the Medicare Shared Savings Program. Harold Miller of the Center for Healthcare Quality and Payment Reform envisions four levels of ACOs, with the core, level one, consisting primarily of primary care practices. Level two would include other specialists and potentially hospitals. As diverse patient populations are included, level three would expand to more specialists and facilities, and level four would include public health and community social services.[4]

The ACO itself must be a separate legal entity with its own tax identification number so that it can receive payments from a third-party payer (e.g., Medicare or a private health plan) and then distribute shared savings payments to providers. It must have processes in place to measure and report quality performance (see more on that below). It must also have a minimal critical mass of patients to justify the time and costs involved in developing the infrastructure and to generate sufficient savings. For the Medicare Shared Savings Program, that minimum is 5,000 beneficiaries.

ACOs are sometimes confused with patient-centered medical homes. It may help to think of the patient-centered medical home as the core of an ACO. However, ACOs tend to offer two components that medical homes do not:

1. Financial incentives. ACOs promote shared accountability by offering financial incentives, such as shared savings or even penalties in some models, motivating provid-

About the Author

Julian "Bo" Bobbitt is an attorney and partner with the Smith Anderson law firm in Raleigh, N.C., where he focuses on providing strategic general counsel and regulatory guidance for health care organizations. This article is based on the AAFP white paper *The Family Physician's ACO Blueprint for Success – Preparing Family Medicine for the Approaching Accountable Care Era* (http://bit.ly/ACOinfo). Author disclosure: no relevant financial affiliations disclosed.

Article Web Address: http://www.aafp.org/fpm/2011/0900/p17.html

ers to work together to deliver the highest quality care at the lowest cost with the greatest patient satisfaction.

2. Specialist/hospital linkages. ACOs tend to have relationships not only with a strong base of primary care physicians but also with other specialists and hospitals across the full continuum of care.

In these respects, ACOs also differ from many of the integrated models thrust upon physicians in the 1990s.

What are the key functions of an ACO?

ACOs are more about function than form. Regardless of the specific organizational structure chosen for an ACO, it must be able to carry out the following key tasks:

1. Creating a culture of teamwork, shared commitment and clinical integration. The most important, and perhaps most difficult, task for an ACO is to create a team-oriented culture with a deeply held, shared commitment to reorganize care to achieve higher quality at lower cost. "While strong hospital-physician alignment has always been a cornerstone of success, the necessary degree of future collaboration, partnership and risk-sharing will dwarf what has come before it," according to an analysis from the Advisory Board Company. "Hospitals and physicians will have to recognize, embrace and leverage their growing interdependence to create organizational structures and incentive models that are strategically aligned and mutually rewarding."[5]

It's important to note that employment does not ensure this type of teamwork and integration. "Current trends in physician

An ACO must be a separate legal entity with its own tax identification number.

The Medicare Shared Savings Program requires ACOs to have a minimum of 5,000 beneficiaries.

One of the most important tasks for an ACO will be creating a clinically integrated team of providers who are committed to shared goals.

SAMPLE PERFORMANCE MEASURES

ACOs will be required to measure and report provider performance. The proposed rule for the Medicare Shared Savings Program recommended 65 measures, a sampling of which are provided below.

Patient/caregiver experience
Timely care, appointments and information
Helpful, courteous and respectful office staff
Patients' ratings of doctor
Shared decision making

Care coordination
30-day post-discharge physician visit
Medication reconciliation
Admissions for uncontrolled diabetes
Percentage of all physicians meeting stage-1 HITECH meaningful use requirements

Patient safety
Blood incompatibility
Pressure ulcer, stages III and IV
Falls and trauma
Catheter-associated UTI

Preventive health
Influenza immunization
Colorectal cancer screening
Cholesterol management for patients with cardiovascular conditions
Tobacco use assessment and tobacco cessation intervention

At-risk population/frail elderly
At-risk population – Diabetes mellitus: hemoglobin A1C control (<8%)
At-risk population – Coronary artery disease: oral antiplatelet therapy prescribed
At-risk population – Chronic obstructive pulmonary disease: spirometry evaluation
At-risk population – Frail elderly: falls: screening for fall risk

employment represent neither a necessary nor sufficient condition for true integration; value-added integration does not necessarily require large-scale physician employment, and simply signing contracts does not ensure progress toward more effective care coordination."[5]

Physicians in ACOs need to understand that they are not simply banding together for contracting purposes. They must be willing to change their utilization, referral and care-management patterns. In many settings, specialists may need to release primary control of patient care decision-making to primary care physicians.

Hospitals and other large entities involved in the ACO also need to be willing to relinquish control and become more collaborative partners. The ACO structure must have meaningful input from the various parties to have status, credibility and long-term success.

An ACO must offer adequate financial incentives to encourage physicians to change their behavior.

2. Establishing adequate financial incentives. Current ACOs are characterized by three tiers of financial incentive models:

• Shared savings: In this model, if an ACO is able to enhance quality and patient satisfaction and achieve savings relative to the predicted costs for the assigned patient population, then the payer shares a portion of those savings (usually 50 percent) with the ACO. In other words, the ACO gets 50 percent of the difference between what the costs for the population turned out to be and what the costs would have been if the ACO had not been in place. This is on top of the providers' fee-for-service payments. The shared savings are divided according to the level of performance of each ACO participant, as determined by benchmarks set by either the ACO or the payer, depending on the agreement in place. (See the next section on performance measurement.) If the ACO's primary care physicians have especially substantial medical home management responsibilities, the ACO may also elect to give them a flat per-member-per-month payment, or care management fee. For example, a primary care physician's compensation might be made up of 50 percent fee-for-service payments, 20 percent care-management fees and 30 percent performance incentives. If fee-for-service payments comprise too high a percentage of physician compensation, there will likely be no substantial change in physician behavior.

Note that an ACO's cost savings should not be determined by simply comparing its population's costs year to year. That might work the first year, but it will be difficult to beat performance levels from the prior year every year. In some CMS demonstration projects, cost savings comparisons were made using relatively unmanaged counties as the control populations. A better approach might be to engage an actuary to predict the medical costs for an ACO's region or comparable community to use as a comparison. The agreement between the ACO and payer should specify how this task will be handled and by whom. ACOs should come within 5 percent, plus or minus, of their predicted costs for three consecutive years before leaving the shared-savings bonus model and taking on risk.[6]

Some ACOs use bonuses only, while others use both bonuses and penalties.

• Savings bonus plus penalty: As with the shared savings model, under this model, providers receive shared savings for managing costs and meeting quality and satisfaction benchmarks. The difference is that they are also liable for expenses that exceed spending targets. This model is called "symmetric" or "two-sided." Providers still receive fee-for-service payments, but to a lesser degree. The bonus potential increases along with the risk.

Under the Medicare Shared Savings Program, ACOs can choose between two versions of this model: one includes risk from year one but offers a larger bonus potential, and the other delays risk until year three and offers a smaller bonus potential.

• Capitation: In a partial or full capitation model, fee-for-service payments would be replaced by a global payment for services, plus potential bonuses and penalties. Only seasoned and truly clinically integrated ACOs should consider taking on this level of risk.

In all of these models, risk adjustment must be in place to ensure that the ACO is not penalized for having sicker patients. Risk adjustment can be as simple as offering different payment levels based on patient age and gender.

ACOs will need to gather and report data to prove that they provide high-quality, cost-effective care.

3. Measuring performance. In the value-based reimbursement era, it will not be enough to simply provide exceptional, cost-effective care. ACOs will also have to prove it by establishing measures, gathering data (including baseline data) and then reporting performance. The proposed rule for the Medicare Shared Savings Program included 65 measures for ACOs (see "Sample performance measures" on page 19). For ACOs in the private marketplace, performance benchmarks may be set by third-party payers, or the ACO

"VALUE-ADDED INTEGRATION DOES NOT NECESSARILY REQUIRE LARGE-SCALE PHYSICIAN EMPLOYMENT, AND SIMPLY SIGNING CONTRACTS DOES NOT ENSURE PROGRESS TOWARD MORE EFFECTIVE CARE COORDINATION."

may be able to select its own, drawing from nationally recognized quality, efficiency and patient satisfaction metrics, where they exist, that match the ACO's targeted initiatives (e.g., improving diabetes care). To gain buy-in on the measures, ACOs may choose to convene a multispecialty committee of clinicians to vet their clinical validity. This committee could also recommend additional performance benchmarks or develop them from scratch if national standards are not yet available for a particular targeted initiative.

4. Implementing best practices across the care continuum. The ultimate goals of accountable care are to improve patient outcomes and patient satisfaction while also achieving greater cost efficiencies. One key to achieving these goals is enhanced coordination of care among diverse providers through the application of evidence-based clinical protocols. The ACO must take the lead in translating evidence-based guidelines into actionable best practices across the continuum of care for selected targeted initiatives. An ACO may start out with a single patient population (i.e., morbidly obese patients) or a single disease state (i.e., diabetes). The best targets for improvement will be clinical areas fraught with waste and inefficiency, unnecessary spending (often related to poor clinical coordination) and unwanted variation in clinical outcomes due to lack of adherence to best clinical practices.[5]

5. Engaging patients. Without patient engagement, an ACO will not fully meet its potential. Many of today's health care consumers erroneously believe that more is better – more tests, more pills, more services – especially when they are not "paying" for it and insurance is. Patient noncompliance is also a real problem, especially regarding chronic diseases and lifestyle management. Understandably, many physicians have difficulty accepting a compensation model based in part on improved health of a patient population when a key variable (patient adherence) is outside the physician's control.

Geisinger Clinic engages patients through use of a patient compact. This is a written commitment by the patient to be responsible for his or her own health, including communicating with the health care team, involving family in the care process, taking medications as prescribed and undertaking appropriate follow-up and preventive care. Patient education, self-care tools and shared decision-making techniques are also key. Additionally, ACOs could partner with insurers to offer benefit differentials based on patients' lifestyle choices, such as smoking or being overweight.

What steps should I take now?

Now that you know the basics of ACOs and how they function, you may be wondering what you need to do to be prepared for this new model. Here are three strategies:

Take the lead. Family physicians who understand ACOs, their key functions, and the potential risks and rewards will be in prime position to provide leadership within their organizations or communities. Every successful ACO starts with a few champions. Family physicians should be among those champions. You can help make sure the ACO has a strong primary care foundation and clear goals that all stakeholders share.

For doctors employed by a hospital: You can still be a leader in this effort. Though your hospital's "top-down" control habits will likely remain until we reach a tipping point in the transition to value-based reimbursement, one of the best things that can happen to a hospital administrator these days is having a well-informed, employed, primary care physician willing to champion an ACO. Try to participate on all relevant ACO feasibility and implementation committees. You may actually have an advantage in raising awareness and developing relationships from the "inside." ➤

Starting with a single patient population or disease state, ACOs must translate evidence-based guidelines into best practices across the continuum of care.

For an ACO to be successful, its patients must be invited into the care process.

By being informed and involved, family physicians can help shape ACO efforts in their communities.

AS A PRIMARY CARE PHYSICIAN, YOU MUST RESIST THE TEMPTATION TO WITHDRAW FROM THESE CHANGES OR TO BLINDLY RUSH INTO NEW ARRANGEMENTS.

To be ready for accountable care, physicians may need to update the systems in their practices.

Physicians may also want to begin forming strategic partnerships, such as medical home networks.

Before aligning with potential ACO partners, physicians should evaluate them carefully.

Assess your practice's readiness for accountable care. Primary care practices that embody the principles of the patient-centered medical home will be best positioned for accountable care. This means having systems in place to optimize patients' access to care, ensure safe prescribing, proactively manage chronic conditions, etc. It also means being prepared for culture change. Family physicians must be willing to cultivate relationships, get outside of their silos and have "what if" creative conversations with open-minded specialists, other primary care physicians, allied health professionals and hospital administrators. Physicians should also assess their health IT systems, their ability to capture data, their patient care capabilities, their patient education and self-support tools, and how they can increase value.

Form strategic partnerships. Individual physicians will have to partner with other physicians, medical groups, hospitals or health systems to participate in the ACO model. These relationships can be loose, such as an IPA, or they can involve full-on employment. There are reports of hospitals scrambling to purchase independent practices in preparation for ACOs, so practices should be prepared for this possibility and proceed with caution. (For additional advice on this topic, AAFP members can download the AAFP white paper *The Family Physician Practice Affiliation Guide* from http://bit.ly/ACOinfo.) As noted previously, employment does not ensure proper teamwork and integration. It will depend on the characteristics of the organization.

One of the most promising arrangements is a medical home network. Physician-owned medical home networks are simply a loose association of primary care practices operating under the patient-centered medical home model. As these networks become more common, a wise strategy may be simply to join an existing one if it has, or soon will have, the capabilities of becoming an ACO. For example, North Carolina has a statewide confederation of 14 medical home networks that operate under a nonprofit umbrella organization, North Carolina Community Care Networks. If a medical home network does not exist in your area, creating one could be an effective strategy. The medical home network can attract a payer interested in efficiencies and quality improvement to become the contracting vehicle. Specialists and hospitals would then contract with the medical home network to help provide the full services of an ACO. Alternatively, a hospital or health system could establish the ACO and then contract with the medical homes to complete its network.

If these options are not available, your strategy should be to evaluate potential ACO partners carefully before aligning with them, and then work to make sure your ACO has a strong primary care base and can carry out the key functions outlined above.

The bad news, and the good news

This is a time of great change in health care, which produces significant stress and uncertainty. As a primary care physician, you must resist the temptation to withdraw from these changes or to blindly rush into new arrangements. Instead, stay informed and involved, and remember that you are key to a high-quality, cost-effective health care system. FPM

Send comments to **fpmedit@aafp.org.**

1. Berwick DM. Launching accountable care organizations – The proposed rule for the Medicare Shared Savings Program. *NEJM*. 2011;364:e32.

2. *Accountable Care Organizations (ACO) Draft 2011 Criteria Overview*. Washington, DC: NCQA; 2010. http://www.ncqa.org/portals/0/publiccomment/ACO/ACO_%20Overview.pdf.

3. Rittenhouse DR, Shortell SM, Fisher ES. Primary care and accountable care: two essential elements of delivery system reform. *NEJM*. 2009;361:2301-2303.

4. Miller HD. *How to Create Accountable Care Organizations*. Pittsburgh: Center for Healthcare Quality and Payment Reform; September 2009. http://www.chqpr.org/downloads/HowtoCreateAccountableCareOrganizations.pdf.

5. *Toward Accountable Care*. Washington, DC: The Advisory Board Company; 2010.

6. Haywood TT, Kosel KC. The ACO model – a three-year financial loss? *NEJM*. 2011;364:e27.

Tame the beast.

It's getting harder to run a successful family practice —especially while struggling to meet ANSI 5010 deadlines, gearing up for ICD-10 and trying to get paid under new reimbursement models. But what if you could keep those hurdles and hassles at bay, get paid what you deserve and stay focused on your patients? Our **cloud-based practice management, EHR and patient communication services** keep you always up to date, help manage all the change, and take administrative burden off your staff. Our **29,000 providers get paid, on average, 9.2% more and 37% faster.*** And since we're cloud-based, you pay **low upfront costs and no ongoing fees for upgrades and maintenance**. Beast tamed. Your focus where it belongs.

Put the power of the cloud to work.
800.587.2606 : athenahealth.com/tamethebeast

athenahealth
$ MORE MONEY ♥ MORE CONTROL

*Our clients see an average 9.2% increase in collections and 37% decrease in DAR. These metrics are based on a weighted average for athenahealth clients with valid pre-athenahealth benchmark data that had their 15-month anniversary with athenahealth during 2009.

ONE LAST ANNUAL ICD-9 UPDATE

The ICD-9 codes that take effect Oct. 1 will be the last. ICD-10 will be implemented in 2013.

Cindy Hughes, CPC

This is it! It's time for the last annual ICD-9 code update. Barring the emergence of a new disease for which a new code would be needed, with this update the codes are frozen to allow time to prepare for the new ICD-10 code set. Once you've made these changes to your encounter forms and superbills, you should turn your attention to learning about ICD-10. Look for help in upcoming issues of *FPM*, where we will offer information and documentation tips to help you with the transition.

In the meantime, we bring you the usual annual ICD-9 updates. You can view *FPM*'s updated ICD-9 "Short List" at right, or download it and the "Long List" version at http://www.aafp.org/fpm/icd9.

***E. coli* infection codes.** Four new codes give physicians the ability to clearly specify *Escherichia coli* infections based on the identification of Shiga toxin-producing *E. coli* or other *E. coli*:

- 041.41 Shiga toxin-producing *E. coli* O157,
- 041.42 Other specified Shiga toxin-producing *E. coli*,
- 041.43 Shiga toxin-producing *E. coli*, unspecified,
- 041.49 Other and unspecified *E. coli*.

Skin codes. Each of the 10 codes in the 173 series for malignant skin cancers has been expanded this year to include a fifth digit: "0" indicates an unspecified malignant neoplasm, "1" indicates a basal cell carcinoma, "2" indicates a squamous cell carcinoma, and "9" indicates an other specified malignant neoplasm. These changes provide 40 code options for reporting basal cell, squamous cell, other specified and unspecified malignancy by site.

Pilar and trichilemmal cysts should now be reported differently from sebaceous cysts by reporting code 704.41, "Pilar cyst," and code 704.42, "Trichilemmal cyst." Sebaceous cysts should still be reported with code 706.2.

Dementia codes. To report dementia of unknown etiology, physicians may now report one of two new ICD-9 codes: 294.20, "Dementia, unspecified, without behavioral disturbance," or 294.21, "Dementia, unspecified, with behavioral disturbance." The latter code includes aggressive, combative and violent behaviors and wandering off.

For patients with mild memory disturbance, report new code 310.89, "Other specified nonpsychotic mental disorders following organic brain damage." This code replaces code 310.8, which is no longer valid. Other new codes in this category include 310.81, "Pseudobulbar affect," and 331.6, "Corticobasal degeneration."

Pregnancy and labor codes. Two new codes identify deliveries that occur earlier than 39 weeks gestation. Those are new code 649.81, "Onset (spontaneous) of labor after 37 completed weeks of gestation but before 39 completed weeks gestation, with delivery by (planned) cesarean section, delivered, with or without mention of antepartum condition," and new code 649.82, which indicates the same scenario but with mention of postpartum complication.

Make note of these additional new obstetrics codes:

- V12.21 Personal history of gestational diabetes,
- V23.42 Pregnancy with history of ectopic pregnancy,
- V23.87 Pregnancy with inconclusive fetal viability,
- 631.0 Inappropriate change in quantitative human chorionic gonadotropin (hCG) in early pregnancy,
- 631.8 Other abnormal products of conception.

On to ICD-10

As you make these changes to your coding tools and documents, make a note of all the places where diagnosis codes are used. These must be revised to include ICD-10 codes before Oct. 1, 2013. You can find a sample ICD-10 transition plan at http://bit.ly/ICD10trans.

If this and all the other changes in health care today are wearing on you, be sure to get lots of rest and some assistance from *FPM* and the AAFP. We don't want your first ICD-10 diagnosis code to be Z56.6, "Other physical and mental strain related to work." FPM

Send comments to **fpmedit@aafp.org.**

About the Author

Cindy Hughes is the AAFP's coding and compliance specialist and is a contributing editor to *Family Practice Management*.

Author disclosure: no relevant financial affiliations disclosed.

Article Web Address: http://www.aafp.org/fpm/2011/0900/p24.html

ICD-9 Codes for Family Medicine 2011-2012: The *FPM* Short List

Family Practice Management®

I. Infectious & Parasitic Diseases

790.7 Bacteremia (not septicemia)
052.9 Chickenpox, NOS
078.11 Condyloma acuminata
111.9 Dermatomycosis, unspec.
057.9 Exanthems, viral, unspec.
007.1 Giardiasis
098.0 Gonorrhea, acute, lower GU tract
041.86 Helicobacter pylori
070.9 Hepatitis, viral, NOS
053.9 Herpes zoster, NOS
054.9 Herpetic disease, uncomplicated
042 HIV disease
V08 HIV positive, asymptomatic
075 Infectious mononucleosis
136.9 Infectious/parasitic diseases, unspec.
487.1 Influenza w/ URI symptoms
007.9 Intestinal protozoa, NOS
088.81 Lyme disease
112.0 Moniliasis, oral
112.3 Moniliasis, skin/nails
112.1 Moniliasis, vulva/vagina
132.0 Pediculosis, head
132.9 Pediculosis, unspec.
127.4 Pinworms
138 Polio, late effects
795.51 Positive PPD
082.0 Rocky mountain spotted fever
003.0 Salmonella gastroenteritis
135 Sarcoidosis
133.0 Scabies
995.91 Sepsis
038.9 Septicemia, NOS
005.0 Staphylococcal food poisoning
➤ 034.0 Strep throat
097.9 Syphilis, unspec.
131.9 Trichomoniasis, unspec.
011.90 Tuberculosis, pulmonary, NOS
099.9 Venereal disease, unspec.
➤ 079.99 Viral infection, unspec.
078.11 Warts, condyloma
➤ 078.10 Warts, viral, unspec.

II. Neoplasms

239.9 Neoplasm, unspec.
239.2 Skin, soft tissue neoplasm, unspec.

Benign Neoplasms

229.9 Benign lesion, unspec.
211.3 Colon
214.9 Lipoma, any site
➤ 216.9 Skin, unspec.

Malignant Neoplasms

188.9 Bladder, unspec.
174.9 Breast, female, unspec.
153.9 Colon, unspec.
184.9 Female genital, unspec., CIS excluded
159.0 Gastrointestinal tract, unspec.
201.90 Hodgkin's, NOS
208.90 Leukemia, unspec., w/o remission
162.9 Lung, unspec.
187.9 Male genital, unspec.
199.1 Malignant lesion, unspec.
185 Prostate
165.9 Respiratory tract, NOS
173.90 Skin, unspec.
189.9 Urinary, unspec.

III. Endocrine, Nutritional & Metabolic Disorders

266.2 B12 deficiency w/o anemia
V85.51 BMI < 5th percentile, pediatric
V85.54 BMI ≥ 95th percentile, pediatric
276.51 Dehydration
➤ 250.01 Diabetes I, uncomplicated
250.91 Diabetes I, w/ unspec. complications
➤ 250.00 Diabetes II, uncomplicated
250.90 Diabetes II, w/ unspec. complications
250.13 Diabetic ketoacidosis, uncontrolled
277.7 Dysmetabolic syndrome
➤ 271.9 Glucose intolerance
240.9 Goiter, unspec.
274.9 Gout, unspec.
275.42 Hypercalcemia
➤ 272.0 Hypercholesterolemia, pure
276.7 Hyperkalemia
272.2 Hyperlipidemia, mixed
272.4 Hyperlipidemia, unspec.
276.0 Hypernatremia
252.00 Hyperparathyroidism, unspec.
242.90 Hyperthyroidism, NOS
275.41 Hypocalcemia
250.80 Hypoglycemia, DM, uncontrolled
251.2 Hypoglycemia, nondiabetic, unspec.
276.8 Hypokalemia
276.1 Hyponatremia
➤ 244.9 Hypothyroidism, unspec.
269.9 Nutritional deficiencies, unspec.
➤ 278.00 Obesity, NOS
➤ 278.02 Overweight
241.0 Thyroid nodule

IV. Blood Diseases

288.9 Abnormal white blood cells, unspec.
285.1 Anemia, acute blood loss
285.29 Anemia, chronic disease, other
285.21 Anemia, chronic kidney disease
285.22 Anemia, chronic neoplastic disease
➤ 280.9 Anemia, iron deficiency, unspec.
➤ 285.9 Anemia, other, unspec.
281.0 Anemia, pernicious
289.9 Blood disease, unspec.
287.9 Hemorrhagic conditions, unspec.
289.81 Hypercoagulable state, primary
288.50 Leukocytopenia, unspec.
289.1 Lymphadenitis, chronic
284.19 Pancytopenia, other
238.4 Polycythemia vera
282.60 Sickle-cell disease, unspec.
282.5 Sickle-cell trait

V. Mental Disorders

309.9 Adjustment reaction, unspec.
305.00 Alcohol abuse, unspec.
303.90 Alcoholism, unspec.
331.0 Alzheimer's
307.1 Anorexia nervosa
➤ 300.00 Anxiety state, unspec.
➤ 314.01 Attention deficit, w/ hyperactivity
314.00 Attention deficit, w/o hyperactivity
307.51 Bulimia nervosa
312.9 Conduct disorder, unspec.
293.0 Delirium, acute
290.0 Dementia, senile, uncomplicated
290.40 Dementia, vascular, uncomplicated
➤ 311 Depressive disorder, NOS
305.90 Drug abuse, unspec.
➤ 307.40 Insomnia, sleep disorder, unspec.
319 Intellectual disabilities, unspec.
315.9 Learning disability/develop. delay, NOS
300.9 Neurosis, NOS
300.01 Panic disorder, no agoraphobia
301.9 Personality disorder, unspec.
302.70 Psychosexual dysfunction., unspec.
298.9 Psychosis, unspec.
295.90 Schizophrenia, unspec.
308.3 Stress, acute situational disturbance
➤ 305.1 Tobacco abuse

VI. Nervous System & Sense Organ Disorders

Ear Diseases

➤ 380.4 Cerumen impaction
388.9 Ear disorder, unspec.
381.50 Eustachian salpingitis, unspec.
389.9 Hearing loss, unspec.
➤ 380.10 Otitis externa, unspec.
➤ 382.00 Otitis media, acute
382.01 Otitis media, acute w/ rupture of TM
381.10 Otitis media, chronic serous
386.2 Vertigo, central
386.10 Vertigo, peripheral, unspec.

Eye Diseases

373.00 Blepharitis, unspec.
366.9 Cataract, unspec.
373.2 Chalazion
➤ 372.30 Conjunctivitis, unspec.
077.99 Conjunctivitis, viral, NOS
918.1 Corneal abrasion
370.00 Corneal ulcer, unspec.
379.90 Eye disorder, unspec.
378.9 Eye movement disorder, unspec.
930.9 Foreign body, eye, external, unspec.
365.9 Glaucoma, unspec.
367.9 Refractive errors, unspec.
362.9 Retinal disorder, unspec.
373.11 Stye (hordeolum)
368.10 Visual disturbance, unspec.
369.9 Visual loss, unspec.

Nervous System Diseases

351.0 Bell's palsy
354.0 Carpal tunnel
➤ 434.91 Cerebral artery occlusion w/ infarction, unspec.
331.83 Cognitive impairment, mild
850.11 Concussion, LOC less than 30 minutes
438.9 CVA, late effect, unspec.
➤ 345.90 Epilepsy, unspec., not intractable
307.81 Headache, tension
432.9 Hemorrhage, intracranial, NOS
322.9 Meningitis, unspec.
➤ 346.90 Migraine, unspec., not intractable
333.90 Movement disorder, unspec.
340 Multiple sclerosis
359.9 Myopathy, unspec.
349.9 Nervous system, NOS
357.9 Neuropathy, unspec.
332.0 Parkinsonism, primary
333.94 Restless legs syndrome
327.23 Sleep apnea, obstructive
333.1 Tremor, essential/familial
781.0 Tremor/spasms, NOS
350.1 Trigeminal neuralgia

VII. Circulatory System

411.1 Angina, unstable
413.9 Angina pectoris, NOS
441.9 Aortic aneurysm, unspec.
447.9 Arterial disorder, other, unspec.
➤ 427.31 Atrial fibrillation
440.9 Atherosclerosis, NOS (not heart/brain)
427.5 Cardiac arrest
➤ 414.9 Chronic ischemic heart disease, unspec.
459.9 Circulatory disorder, unspec.
426.9 Conduction disorder, unspec.
➤ 796.2 Elevated BP w/o hypertension
429.9 Heart disease, other, unspec.
428.40 Heart failure, combined, unspec.
➤ 428.0 Heart failure, congestive, unspec.
428.30 Heart failure, diastolic, unspec.
428.20 Heart failure, systolic, unspec.
424.1 Heart valve, aortic, not rheum.
424.0 Heart valve, mitral, not rheum.
424.3 Heart valve, pulmonary, not rheum.
424.2 Heart valve, tricuspid, not rheum.
➤ 401.1 Hypertension, benign
401.0 Hypertension, malignant
➤ 401.9 Hypertension, unspec.
402.91 Hypertensive heart disease, unspec., w/ heart failure
403.90 Hypertensive renal disease w/o renal failure, unspec.
458.0 Hypotension, orthostatic
426.82 Long QT syndrome
410.90 MI, NOS (to 8 weeks)
410.70 MI, NSTEMI (to 8 weeks)
412 MI, old
420.91 Pericarditis, acute, nonspecific
443.9 Peripheral vascular disease, unspec.
➤ 451.19 Phlebitis, deep, lower extrem., other
427.60 Premature beats, unspec.
428.1 Pulmonary edema, acute
415.19 Pulmonary embolism, not iatrogenic
416.9 Pulmonary heart disease, chronic, unspec.
398.90 Rheumatic heart disease, unspec.
427.81 Sick sinus syndrome
427.0 Tachycardia, paroxysmal SVT
451.9 Thrombophlebitis, unspec.
435.9 Transient ischemic attack, unspec.
454.9 Varicose veins, asymptomatic
459.81 Venous insufficiency, unspec.

VIII. Respiratory System

493.81 Asthma, exercise induced
493.02 Asthma, extrinsic, acute exacerbation
493.12 Asthma, intrinsic, acute exacerbation
➤ 493.90 Asthma, unspec.
466.11 Bronchiolitis, acute, due to RSV
➤ 466.0 Bronchitis, acute
491.9 Bronchitis, chronic, unspec.
519.11 Bronchospasm, acute
➤ 496 COPD, NOS
464.4 Croup
492.8 Emphysema
464.00 Laryngitis, acute, no obstruction
475 Peritonsillar abscess
➤ 462 Pharyngitis, acute
511.9 Pleural effusion, NOS
511.0 Pleurisy, NOS
➤ 486 Pneumonia, unspec.
512.81 Pneumothorax, spontaneous, primary
519.9 Respiratory disease, other, NOS
➤ 477.9 Rhinitis, allergic, cause unspec.
472.0 Rhinitis, chronic
461.1 Sinusitis, acute, frontal
461.0 Sinusitis, acute, maxillary
➤ 461.9 Sinusitis, acute, NOS
473.1 Sinusitis, chronic, frontal
473.0 Sinusitis, chronic, maxillary
473.9 Sinusitis, chronic, NOS
474.9 Tonsil/adenoid disease, chronic, unspec.
463 Tonsillitis, acute
➤ 465.9 Upper respiratory infection, acute, NOS

IX. Digestive System

565.0 Anal fissure, nontraumatic
540.9 Appendicitis, unspec.
575.0 Cholecystitis, acute
574.20 Cholelithiasis, NOS
571.5 Cirrhosis, NOS
➤ 564.00 Constipation, unspec.
555.9 Crohn's disease, NOS
525.9 Dental, unspec.
522.5 Dental abscess
521.00 Dental caries, unspec.
562.11 Diverticulitis of colon, NOS
562.10 Diverticulosis of colon
536.8 Dyspepsia
530.9 Esophageal disease, unspec.
530.10 Esophagitis, unspec.
564.9 Functional disorder intestine, unspec.
575.9 Gallbladder disease, unspec.
535.50 Gastritis, unspec., w/o hemorrhage
009.1 Gastroenteritis, infectious
➤ 558.9 Gastroenteritis, noninfectious, unspec.
➤ 530.81 Gastroesophageal reflux, no esophagitis
➤ 455.6 Hemorrhoids, NOS
553.3 Hernia, hiatal, noncongenital
550.90 Hernia, inguinal, NOS
553.9 Hernia, other, NOS
560.1 Ileus
560.9 Intestinal obstruction, unspec.
564.1 Irritable bowel syndrome
571.9 Liver disease, chronic, unspec.
528.9 Oral, soft tissue diseases, unspec.
529.9 Oral, tongue diseases, unspec.
577.0 Pancreatitis, acute
528.00 Stomatitis, mucositis, unspec.
524.60 TMJ disorder, unspec.
556.9 Ulcerative colitis, unspec.

X. Genitourinary System

Breast Diseases

611.9 Breast disease, unspec.
611.72 Breast lump
610.2 Fibroadenosis
610.1 Fibrocystic disease
611.6 Galactorrhea
675.90 Mastitis, lactating, unspec.
611.0 Mastitis, NOS

Disorders of Menstruation

626.0 Amenorrhea
V07.4 Hormone replacement therapy, postmenopausal
➤ 627.9 Menopausal disorders, unspec.
➤ 626.2 Menstruation, excessive/frequent
625.3 Menstruation, painful
626.6 Metrorrhagia
625.4 Premenstrual tension syndrome

Female Genital Organ Diseases

616.2 Bartholin cyst
622.7 Cervical polyp, NOS
616.0 Cervicitis
620.0 Cyst of ovary, follicular
618.9 Cystocele/rectocele/prolapse, unspec.
625.0 Dyspareunia
617.9 Endometriosis, unspec.
629.9 Female genital disease, unspec.
218.9 Fibroid uterus (leiomyoma), unspec.
614.9 Pelvic inflammatory disease, unspec.
➤ 616.10 Vaginitis/vulvitis, unspec.

Fertility Problems

628.9 Infertility, female, unspec.
606.9 Infertility, male, unspec.

Male Genital Organ Diseases

607.1 Balanitis
600.01 BPH/LUTS w/ obstruction
➤ 600.00 BPH/LUTS w/o obstruction
603.9 Hydrocele, unspec.
607.84 Impotence, organic
302.72 Impotence, psychosexual dysfunction
608.9 Male genital disease, other, unspec.
604.90 Orchitis/epididymitis, unspec.
605 Phimosis
➤ 601.9 Prostatitis, NOS
790.93 PSA, elevated
099.40 Urethritis, nongonococcal, unspec.
456.4 Varicocele

Urinary System Diseases

592.9 Calculus, urinary, unspec.
➤ 595.0 Cystitis, acute
595.1 Cystitis, interstitial, chronic
580.9 Glomerulonephritis, acute, unspec.
582.9 Glomerulonephritis, chronic, unspec.
599.70 Hematuria, unspec.
625.6 Incontinence, stress, female
585.9 Kidney disease, chronic, unspec.
590.10 Pyelonephritis, acute, w/o necrosis
584.9 Renal failure, acute, unspec.
593.9 Renal insufficiency, acute
597.81 Urethral syndrome, non-VD, NOS
599.60 Urinary obstruction, unspec.
➤ 599.0 Urinary tract infection, unspec./pyuria

XI. Pregnancy, Childbirth

635.90 Abortion, induced, w/o complication
634.90 Abortion, spontaneous, w/o complication
641.20 Abruptio placentae, unspec.
641.90 Bleeding in pregnancy, unspec.
669.90 Complicated delivery/labor, unspec.
655.70 Decreased fetal movements, unspec.
633.90 Ectopic pregnancy, no IUP, unspec.
670.14 Endometritis, postpartum
642.30 Gestational hypertension, unspec.
650 Normal delivery
674.94 Other complication of puerperium/postpartum, unspec.
641.10 Placenta previa, w/ bleeding, unspec.
641.00 Placenta previa, w/o bleeding, unspec.
➤ V24.2 Postpartum follow-up, routine
642.40 Pre-eclampsia, unspec.
646.90 Pregnancy, other complications, unspec.
V72.4 Pregnancy exam or test
V22.2 Pregnant state, incidental
644.21 Premature labor, delivered
644.03 Premature labor, threat., undelivered
V23.9 Prenatal care, high risk, unspec.
➤ V22.0 Prenatal care, normal, first pregnancy
➤ V22.1 Prenatal care, normal, other pregnancy
649.5 Spotting in pregnancy
640.00 Threatened abortion, unspec.
651.00 Twins, unspec.
646.60 UTI in pregnancy, unspec.
643.90 Vomiting of pregnancy, unspec.

XII. Skin, Subcutaneous Tissue

➤ 706.1 Acne, other
702.0 Actinic keratosis
704.00 Alopecia, unspec.
➤ 682.9 Cellulitis/abscess, unspec.
➤ 692.9 Contact dermatitis, NOS
700 Corn/callus
691.0 Diaper rash
➤ 691.8 Eczema, atopic dermatitis
704.9 Hair disease, unspec.
704.1 Hirsutism
684 Impetigo
703.0 Ingrown nail
683 Lymphadenitis, acute
703.9 Nail disease, unspec.
110.1 Onychomycosis
696.3 Pityriasis rosea
698.9 Pruritus, NOS
696.1 Psoriasis, NOS
695.3 Rosacea
➤ 706.2 Sebaceous cyst
690.10 Seborrheic dermatitis, NOS
702.19 Seborrheic keratosis, NOS
➤ 709.9 Skin disease, other, unspec.
692.71 Sunburn
705.9 Sweat gland disease, unspec.
111.0 Tinea versicolor
707.9 Ulcer, skin, chronic, unspec.
708.9 Urticaria, unspec.

XIII. Musculoskeletal & Connective Tissue

736.9 Acquired deformity, limb, unspec.
716.10 Arthropathy, traumatic, unspec.
➤ 716.90 Arthropathy, unspec.
➤ 724.4 Back pain w/ radiation, unspec.
➤ 723.9 Cervical disorder, NOS
710.9 Connective tissue disease, unspec.
717.9 Derangement, knee, internal, unspec.
722.2 Disc syndrome, no myelopathy, NOS
➤ 729.1 Fibromyalgia/myositis, unspec.
727.43 Ganglion, unspec.
737.9 Kyphosis/scoliosis, unspec.
728.87 Muscle weakness, generalized
721.90 Osteoarthritis of spine, NOS
➤ 715.90 Osteoarthrosis, unspec.
730.00 Osteomyelitis, acute, unspec.
730.10 Osteomyelitis, chronic, unspec.
733.00 Osteoporosis, unspec.
➤ 729.5 Pain in limb
725 Polymyalgia rheumatica
714.0 Rheumatoid arthritis (not JRA)
➤ 726.10 Rotator cuff/shoulder synd., unspec.
➤ 727.00 Synovitis/tenosynovitis, unspec.

XIV. Congenital Anomalies

759.9 Congenital anomaly, other, unspec.
746.9 Congenital heart anomaly, NOS
755.9 Limb anomaly, unspec.
750.5 Pyloric stenosis
743.65 Tear duct, blocked
752.51 Undescended testis

XV. Perinatal (Infant)

768.9 Birth asphyxia, unspec.
767.9 Birth trauma, unspec.
779.31 Feeding problem, newborn
768.4 Fetal distress, unspec.
770.88 Hypoxemia, newborn, NOS
774.30 Jaundice, newborn, unspec.
764.00 Newborn, SGA, weight unspec.
779.9 Perinatal morbidity/mortality, unspec.
766.21 Post-term infant
765.10 Preterm infant, weight unspec.
769 Respiratory distress syndrome
770.9 Respiratory problem, other, unspec.
771.81 Sepsis, neonatal
778.9 Skin/temperature problem
798.0 Sudden infant death syndrome
V30.00 Well newborn, hospital birth, vaginal

XVI. Signs & Symptoms

➤ 789.00 Abdominal pain/colic, unspec.
790.6 Abnormal blood chemistry, other
794.31 Abnormal electrocardiogram
790.29 Abnormal glucose, other
795.05 Abnormal HPV, positive, cervical high risk
793.19 Abnormal imaging, lung, other
➤ 783.21 Abnormal loss of weight
795.02 Abnormal Pap, ASC, possible HGSIL
➤ 795.01 Abnormal Pap, ASC-US
➤ 795.00 Abnormal Pap, glandular, NOS
790.4 Abnormal transaminase/LDH
790.09 Abnormalities of RBCs
995.0 Anaphylactic reaction, other
783.0 Anorexia
719.40 Arthralgia, unspec.
789.51 Ascites, malignant
789.59 Ascites, other
569.3 Bleeding, rectal
578.1 Blood in stool, melena
792.1 Blood in stool, occult
➤ 786.50 Chest pain, unspec.
780.71 Chronic fatigue syndrome
338.28 Chronic pain, other post-op
338.22 Chronic pain, post-thoracotomy
780.01 Coma, nondiabetic/nonhepatic
➤ 786.2 Cough
780.92 Crying, infant, excessive
➤ 787.91 Diarrhea, NOS
➤ 780.4 Dizziness/vertigo, NOS
787.20 Dysphagia, unspec.
➤ 788.1 Dysuria
➤ 782.3 Edema, localized, NOS
719.00 Effusion/swelling of joint, unspec.
784.7 Epistaxis
783.41 Failure to thrive, child
➤ 780.79 Fatigue and malaise, other
787.60 Fecal incontinence, full
783.3 Feeding problem, infant/elderly
➤ 780.60 Fever, unspec.
787.3 Gas/bloating
791.5 Glycosuria
➤ 784.0 Headache, unspec.
787.1 Heartburn
578.0 Hematemesis
786.30 Hemoptysis, unspecified
789.1 Hepatomegaly
786.8 Hiccups
784.42 Hoarseness
306.1 Hyperventilation
799.02 Hypoxemia
788.30 Incontinence/enuresis, NOS
783.40 Lack of normal physiological development, unspec.
799.81 Libido, decreased
782.2 Localized swelling/mass, superficial
785.6 Lymph nodes, enlarged
793.80 Mammogram, abnormal, unspec.
780.93 Memory loss
780.02 Mental status changes
785.2 Murmur of heart, undiagnosed
787.02 Nausea, alone
➤ 787.01 Nausea w/ vomiting
788.43 Nocturia
799.89 Other ill-defined conditions
338.21 Pain, chronic, due to trauma
338.29 Pain, chronic, other
➤ 719.46 Pain, knee
➤ 724.2 Pain, low back
338.3 Pain, neoplasm related
338.4 Pain syndrome, chronic
➤ 785.1 Palpitations
788.42 Polyuria
791.0 Proteinuria, nonpostural, nonobstetric
➤ 782.1 Rash, nonvesicular, unspec.
780.39 Seizures, convulsions, other
780.31 Seizures, simple, febrile, unspec.
780.09 Semicoma, stupor
782.0 Sensory disturbance skin
785.50 Shock, unspec.
➤ 786.05 Shortness of breath
782.9 Skin, other symptoms
789.2 Splenomegaly
780.8 Sweating, excessive
780.2 Syncope
➤ 788.41 Urinary frequency
788.63 Urinary urgency
787.03 Vomiting, alone
719.7 Walking difficulty
786.07 Wheezing

XVII. Injuries & Adverse Effects

Dislocations, Sprains & Strains

839.8 Dislocation: other, closed, unspec.
831.00 Dislocation: shoulder, closed, unspec.
836.2 Knee meniscus injury, unspec.
➤ 845.00 Sprain/strain: ankle, unspec.
845.10 Sprain/strain: foot, unspec.
842.10 Sprain/strain: hand, unspec.
➤ 844.9 Sprain/strain: knee/leg, unspec.
➤ 847.0 Sprain/strain: neck, unspec.
848.9 Sprain/strain: other site, unspec.
➤ 840.9 Sprain/strain: shoulder/arm, unspec.
847.9 Sprain/strain: vertebral, unspec.
842.00 Sprain/strain: wrist, unspec.

Fracture

824.8 Fracture: ankle, closed, unspec.
814.00 Fracture: carpal, closed, unspec.
810.00 Fracture: clavicle, closed, unspec.
820.8 Fracture: femur/hip, closed, unspec.
821.01 Fracture: femur/shaft, closed
823.81 Fracture: fibula, closed, unspec.
825.20 Fracture: foot, closed, unspec. (not toes)
813.80 Fracture: forearm, closed, unspec.
812.20 Fracture: humerus, closed, unspec.
802.20 Fracture: mandible, closed, unspec.
815.00 Fracture: metacarpal, closed, unspec.
802.0 Fracture: nose, closed
829.0 Fracture: other sites, closed, unspec.
808.8 Fracture: pelvic, closed, unspec.
826.0 Fracture: phalanges, foot, closed
816.00 Fracture: phalanges, hand, closed, unspec.
807.00 Fracture: ribs, closed, unspec.
803.00 Fracture: skull, closed, unspec.
823.80 Fracture: tibia, closed, unspec.
823.82 Fracture: tibia/fibula, closed, unspec.
805.8 Fracture: vertebral, closed, unspec.
733.94 Fracture, stress: metatarsals
733.95 Fracture, stress: other bone
733.93 Fracture, stress: tibia or fibula
V67.4 Healed fracture, follow-up exam

Other Trauma, Adverse Effects

919.0 Abrasion, unspec.
995.81 Adult physical abuse
949.0 Burn, degree unspec.
995.50 Child abuse, unspec.
991.9 Cold injury, unspec.
850.9 Concussion, unspec.
➤ 924.9 Contusion, unspec.
929.9 Crushing injury, unspec.
994.4 Exhaustion due to exposure
938 Foreign body, digestive system, unspec.
931 Foreign body, ear
932 Foreign body, nose
919.6 Foreign body, skin, superficial, unspec.
E922.9 Gunshot wound, NOS
854.00 Head injury, NOS
992.9 Heat injury, unspec.
919.4 Insect bite
908.9 Late effects of injury, unspec.
995.20 Medication, adverse effects, unspec.
879.8 Open wound, head/neck/trunk, unspec.
894.0 Open wound, lower limb, unspec.
884.0 Open wound, upper limb, unspec.
959.9 Other trauma, unspec.
977.9 Poisoning, medicine overdose, unspec.
989.9 Poisoning, nonmedicinal substance
V71.5 Rape

XVIII. Supplemental Classification

V68.9 Administrative, other, unspec.
V65.40 Advice/health instruction, NOS
V58.61 Anticoagulant therapy, long term
V61.49 Caring for family/household member
V13.22 Cervical dysplasia, past history
V50.2 Circumcision, routine
V25.5 Contraception, Norplant insertion
V25.01 Contraception, oral
➤ V25.02 Contraception, other (diaphragm, etc.)
V25.09 Contraception advice
V25.9 Contraception management, unspec.
➤ V25.40 Contraception surveillance, unspec.
V61.10 Counseling for marital and partner problems, unspec.
V61.20 Counseling for parent/child problems, unspec.
V68.01 Disability exam
V49.86 Do not resuscitate status
V60.2 Economic problem
V62.3 Educational problem
V01.9 Exposure to infectious disease, unspec.
V01.6 Exposure to venereal disease
V15.88 Falls: risk for, history of
V61.09 Family disruption, other
V61.9 Family problem, other, unspec.
V67.00 Follow-up exam, surgery, unspec.
V68.09 Form, other
➤ V72.31 Gynecological exam
➤ V58.69 High-risk medication, long-term use
V60.0 Housing problem/homeless
V06.8 Immunization, combination, other
V06.9 Immunization, combination, unspec.
V06.1 Immunization, DTP
➤ V04.81 Immunization, influenza
V05.9 Immunization, single, unspec.
V62.5 Legal problem
V71.81 Observation, suspected abuse & neglect
V65.11 Pediatric pre-birth visit, expectant parent(s)
V65.19 Person consulting on behalf of another
V72.84 Pre-op exam, unspec.
V61.3 Problem w/ aged parents or in-laws
V62.9 Psychosocial problem, unspec.
V68.81 Referral w/o exam
V76.51 Screening, cancer, colon
V76.9 Screening, cancer, unspec.
V81.0 Screening, cardiac disease
V77.1 Screening, diabetes
V77.91 Screening, lipoid disorders
V76.44 Screening, PSA
V82.9 Screening, unspec.
V62.4 Social maladjustment
V25.2 Sterilization
V58.31 Surgical wound dressing
V58.32 Suture removal
➤ V70.0 Well adult exam
➤ V20.2 Well child check

Note: Codes that include NOS (not otherwise specified) or unspec. (unspecified) have alternative diagnosis codes that are more specific. These alternatives can be found in or near the section of ICD-9-CM that deals with the relevant three-digit codes. The 100 codes that are preceded by an arrow (➤) have been identified by the authors as especially common in family medicine.

This list reflects changes that took effect Oct. 1, 2011. For more information about this year's ICD-9 changes, see "One Last Annual ICD-9 Update." Hughes C. *Family Practice Management*. September/October 2011:24. http://www.aafp.org/fpm/2011/0900/p24.html.

Compiled by Donald Spencer, MD, MBA, of the Department of Family Medicine, University of North Carolina, Chapel Hill; Philip S. Whitecar, MD, of the Department of Family Medicine, Wright State University, Dayton, Ohio; and Allen Daugird, MD, MBA, of the Department of Family Medicine, University of North Carolina, Chapel Hill. Author disclosure: no relevant financial affiliations disclosed.

Printed copies of this list may be purchased through the AAFP online catalog at http://www.aafp.org/shop/fpm/icd9 or by calling the AAFP Contact Center at 800-274-2237. This list and the *FPM* "Long List" can be downloaded from the *FPM* web site at http://www.aafp.org/fpm/icd9.

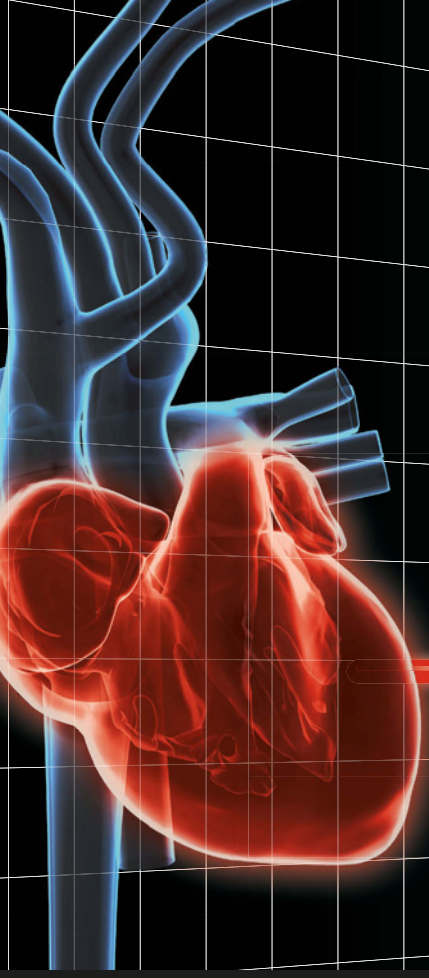
Portions copyright © 2011 American Academy of Family Physicians.

Please use the space below for notes or additional codes common in your practice.

AAFP

HoMedics®

Blood Pressure Monitors



The accuracy your patients need.

The innovation and value they want.

Now available with VOICE ASSIST™
Talking function announces instructions and results

WORKS WITH Microsoft® HealthVault™

HoMedics Blood Pressure Monitors:

- Are clinically validated to the ANSI/AAMI SP10 standard
- Span a wide range of innovative features that make monitoring blood pressure at home easier than ever, including:
  - Voice Assist™ Talking Function that offers instructions and announces results
  - Standard & large size arm cuffs to fit most arm sizes
  - Microsoft® HealthVault™ compatibility
  - Irregular Heartbeat Detector, Risk Category Index and more!

See the full line at **www.homedics.com**

HealthVault™ name and logo, and Microsoft® are either registered trademarks or trademarks of Microsoft Corporation in the United States and/or other countries.

Remove Roadblocks and Improve Access to Preventive Care

Learn how a few procedural changes dramatically increased this practice's visit rates for well-child care.

Delivering quality patient care is goal number one for most medical practices, but good intentions are not always enough if your management processes keep getting in the way.

Fort Wayne Medical Education Program (FWMEP), a family medicine residency program in Indiana, reached this conclusion after one of its payers, AmeriHealth Mercy of Indiana, revealed less-than-stellar outcomes for patients who had selected FWMEP physicians for their care. As if that wasn't bad enough, the outcomes were for an especially important patient population – children insured by Indiana's Medicaid program.

To address this, the practice teamed with AmeriHealth Mercy of Indiana and a consultant (Woodcock) to improve its delivery of preventive care to children, honing in on well-child care for Medicaid patients. FWMEP quickly recognized that roadblocks of its own making were preventing the practice from reaching its goals. By

Elizabeth W. Woodcock, MBA, FACMPE, CPC, Eric Whicker, Leann Hostetler, RN, and Devon Nichols, MBA

SEAN KANE

removing these roadblocks as described below, FWMEP is improving its quality indicator scores and, most important, giving patients the care they need. We hope that other practices can learn from our experience.

Scheduling visits more effectively

As a busy practice seeing 100 patients a day, FWMEP excelled at quickly scheduling patients with acute problems. Fifteen appointment slots were held open for acute care each morning and afternoon. Patients who needed only preventive care didn't "qualify" for these slots, so they were given appointments two or more weeks out. This policy exacerbated the chronically high rate of cancellations and no shows for appointments with Medicaid-insured children. The parents and guardians of these patients face numerous challenges – arranging childcare, adjusting work schedules and finding transportation, to name a few – so setting appointments to suit our schedule instead of their schedule posed a significant roadblock. Recognizing this, FWMEP reduced its restrictions on appointment availability for preventive care, initiating a modified open-access system for all appointment requests.

The practice also redoubled its efforts to encourage parents and guardians to schedule well-child checks for their children. The practice now identifies patients who need well-child care by querying monthly member reports provided by AmeriHealth Mercy of Indiana and calling their parents and guardians to offer appointments. Staff spend from one to three hours a day on this work, which includes identifying patients newly assigned to the practice and then calling each one to welcome them to the practice and schedule a well-child check.

The practice developed two brochures that highlight the need for preventive care, one for young children and the other for adolescents. These are given to patients and parents at their appointments, and the practice plans to broaden distribution to patients who are not scheduling preventive exams regularly.

The practice also plans to implement an appointment recall process driven by its electronic health record system (EHR) to ensure follow-up on all patients to whom it has recommended care.

Providing two visits in one

After analyzing payer reports, FWMEP discovered that 35 percent of the pediatric patients assigned to the practice had been seen for acute issues during the first eight months of the year but weren't up-to-date on well-child care. Although the practice routinely asked parents and guardians at checkout to schedule well-child care, the majority failed to keep their appointments. Adding to the challenge was the fact that the practice could not schedule appointments more than 13 weeks out due to internal constraints regarding physician schedules. If the well-child appointment couldn't be scheduled at checkout, a staff member handed the parent or guardian a reminder card and asked them to call back in a few months; however, the practice did not follow up. The practice came to realize that the best opportunity to provide well-child care for these patients was when they were seen for an acute problem.

> Good intentions are not always enough if your management processes keep getting in the way.

One hurdle to implementing a "double visit" protocol was a lack of coding and reimbursement knowledge among the practice's physicians. They wanted assurance that a well-child check (CPT codes 99381-99387; 99391-99397) would be paid for when billed with a problem-focused office visit provided the same day (CPT codes 99201-99215; 99211-99215). Physicians were taught how to distinctly document both services in the patient's electronic health record and properly code them with use of modifier 25 to indicate that a significant,

About the Authors

Elizabeth Woodcock is a practice management consultant and principal of Woodcock & Associates Inc. in Atlanta. Eric Whicker is chief financial officer of Fort Wayne Medical Education Program (FWMEP), a family medicine residency program in northeastern Indiana. Leann Hostetler is a research nurse at FWMEP. Devon Nichols is director of compliance and quality with AmeriHealth Mercy of Indiana. Author disclosure: AmeriHealth Mercy engaged Elizabeth Woodcock to serve as a practice management consultant to FWMEP for the initiative described in the article.

Article Web Address: http://www.aafp.org/fpm/2011/0900/p26.html

separately identifiable service was provided on the same day. (For more on modifier 25, see "Understanding When to Use Modifier 25," *FPM,* October 2004, http://www.aafp.org/fpm/2004/1000/p21.html.) The practice confirmed with the payer that payment would be provided for both services, and business office staff reviewed remittances to verify payment.

Next FWMEP turned its attention to making sure that recommended well-child care could actually be addressed in the context of the acute care visit. The practice instructed its schedulers to add 10 minutes to all pediatric acute-care appointment slots with the expectation that both the acute visit and a well-child check would be performed. Initially this created consternation, but a careful review revealed that adding 10 minutes to accommodate well-child checks was not disruptive and in fact optimized the physician's time. The practice's reduction in no-shows for separately scheduled pediatric preventive visits more than offset the reduction in pediatric acute-care appointments. Volume actually increased.

The practice's EHR system became an essential tool for identifying needed preventive services at the point of care when alerts for age-appropriate immunizations were added to the system. The EHR was programmed to display an alert for preventive care whenever an FWMEP nurse logs in to a pediatric patient's record to initiate a patient encounter. In addition, the practice trained physicians and nurses to use templates specific to visit types to navigate patient encounters and ease documentation, which improved efficiency.

To further encourage improving immunization rates and the percentage of children receiving well-child care, the practice is evaluating offering a productivity incentive, gasoline gift cards, to all staff.

Addressing well-child care in the context of acute-care visits helped this practice improve care to a vulnerable population – children insured by Medicaid.

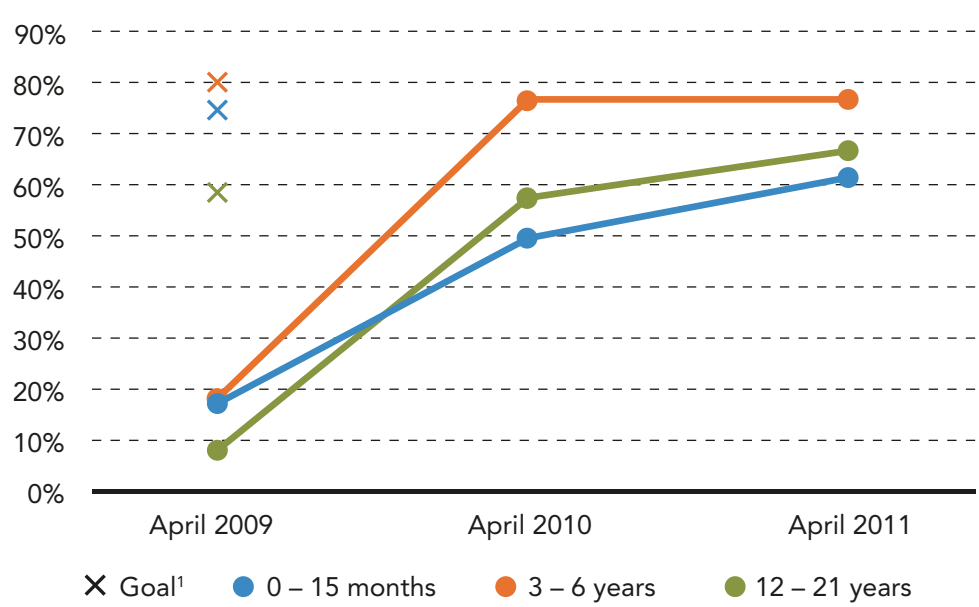
To make time for well-child care, the practice added 10 minutes to all pediatric acute-care appointments; volume increased.

Preventive care templates and alerts in the EHR helped improve efficiency.

Reducing missed appointments

A 14 percent no-show rate made missed appointments an obvious target for the performance initiative. The rate of no-shows for well-child checks with Medicaid patients was significantly higher, at 22 percent. Even more disheartening was realizing that 14 percent of all scheduled visits and 13 percent of Medicaid scheduled well-child checks resulted in cancellations. Because those slots were not rebooked, the overall rate of missed encounters was 28 percent for all patients and 35 percent for Medicaid well-child checks.

PERCENTAGE OF PEDIATRIC MEDICAID PATIENTS RECEIVING WELL-CHILD CHECKS AT RECOMMENDED INTERVALS



[1]Goal based on HEDIS performance goals for 2009 established by the Indiana Office of Medicaid Planning and Policy.

TIPS FOR IMPROVING WELL-CHILD VISIT RATES

- Reduce restrictions on appointment availability.
- Use payers' monthly member reports to identify pediatric patients newly assigned to the practice; call each family to welcome them and schedule a well-child visit.
- Develop an information sheet that highlights the importance of preventive care. Give this to patients and their parents at acute care appointments.
- Implement a reminder system and recall process to ensure that patients' parents follow through on recommended preventive care.
- Provide well-child care for patients when they are seen for an acute problem; check with payers to confirm that same-day acute and well-child care are separately billable.
- Use visit-specific templates for reminders and to ease documentation.
- Evaluate missed-appointment letters to ensure that contact information and tone are right.
- Ask payers what they will do to support your efforts.
- Use an appointment reminder system; consider warm calls in addition to automated ones.
- Rather than turning away patients who arrive late, allow the physician to determine whether he or she can still see them.
- Have physicians deliver discharge paperwork for newborn patients directly to the practice's triage nurse to contact the parents about scheduling newborn and postpartum visits.

To address these issues, the practice took a closer look at the letters sent to patients who missed their appointments. FWMEP discovered that although they asked patients to reschedule, the letters contained no information about how to contact the practice. The practice designed a new letter displaying the practice's phone number prominently and using less confrontational language to advise patients of the "missed" (rather than "failed") appointment. FWMEP also gained the support of AmeriHealth Mercy of Indiana, which agreed to handle communications when patients missed three or more appointments.

The practice also revised its procedure for appointment confirmation calls. Although patients continue to receive appointment reminders from an automated system two days prior to their scheduled appointment, the front office staff also makes "warm calls" the day before the appointment to parents or guardians of children scheduled for well-child checks.

Finally, the practice decided to take a different approach when patients arrive more than 20 minutes late for appointments. Rather than turning them away, the front office contacts the patient's physician to determine whether he or she can still see the patient.

Increasing newborn care

A quick review of the compliance rate for newborn visits revealed a gap that the practice knew it needed to close, starting with a revision of the discharge paperwork given to new mothers. Buried in a litany of postpartum advice was a one-line statement in small print with instructions to call the practice to make an appointment for postpartum care four weeks after delivery. The instructions did not address the need for a newborn visit at all. Because the practice had no tracking system, if the appointment wasn't scheduled the practice might never see the mom or baby again – or recognize that it should.

To prevent postpartum and initial newborn care from falling through the cracks, the physicians who provide hospital care to moms and babies now carry the discharge paperwork for each of their patients to one of the two triage nurses employed by the practice. The nurse follows up directly with the patient to schedule the newborn and postpartum visits. Patients receive an automated confirmation call two days before these appointments, and the practice added a "warm call" as well.

The practice is considering developing a

The practice also took steps to reduce its no-show rate, which was 22 percent for well-child checks with Medicaid beneficiaries.

To improve newborn care, the practice revised its discharge paperwork to clearly instruct new mothers to schedule a newborn visit.

Nurses now work directly with new mothers to schedule newborn visits as well as postpartum visits.

The percentage of Medicaid patients who receive appropriate well-child care has increased dramatically in two years.

Small system changes throughout the practice contributed to improved care delivery.

postpartum and nursery standing-order sheet to instruct hospital ward clerks to contact the practice before the patient is discharged from the hospital to schedule the postpartum and newborn checks.

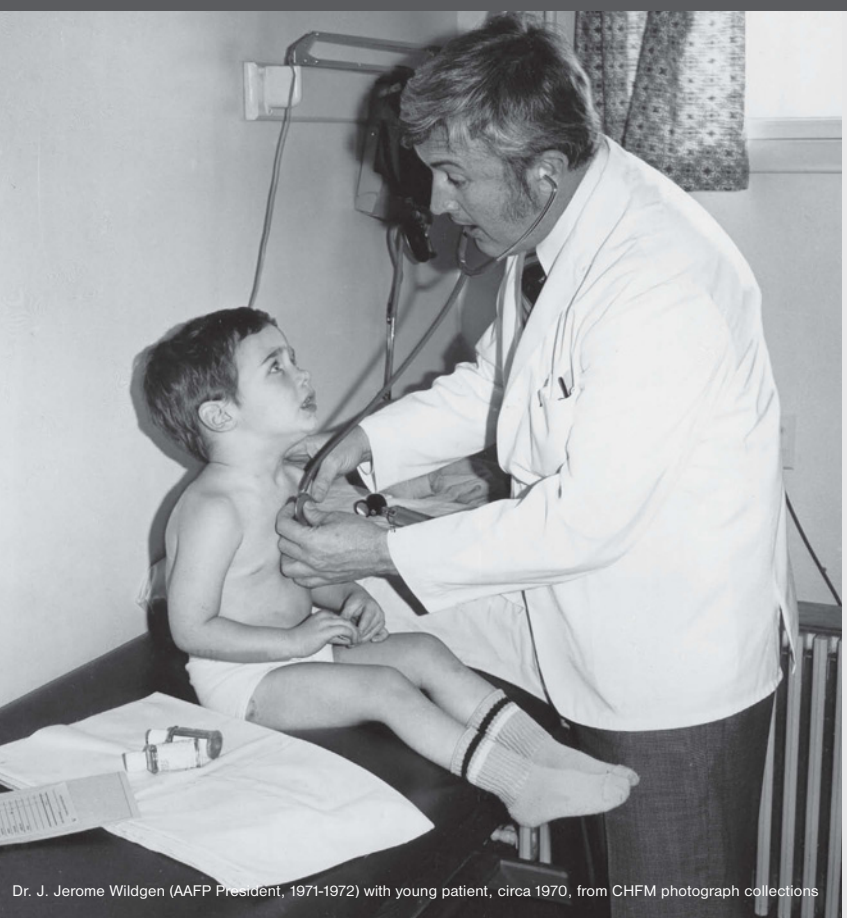
Positive results

Improvement resulted quickly following the implementation of these changes. The volume of Medicaid well-child checks increased by 32 percent. In addition, the practice dramatically increased the percentage of Medicaid pediatric patients who receive well-child checks at recommended intervals (see the graph on page 28). Data collected at the end of the second year show that performance has continued to improve.

The new scheduling protocols – welcome calls to new patients, confirmation calls for all well-child checks and postpartum follow-up calls – were accommodated by existing staff after streamlining and redistributing workloads. Supported by a system that makes better use of providers' time, instead of just adding more hours, the practice's volume and revenue both increased. Most important, children are receiving the preventive care they need. This initiative has shown that improving outcomes may involve much more than reviewing what goes on in the exam room. Better outcomes may well depend upon uncovering and removing the roadblocks a practice creates in how it manages access. FPM

Send comments to **fpmedit@aafp.org.**

Editor's note: The authors wish to acknowledge the contributions of the following individuals, all from the Fort Wayne Medical Education Program: James E. Buchanan, MD, Robert Wilkins, MD, Rebecca Baker-Palmer, MD, Aaron Coray, DO, J. David Kunberger, MD, Vip Mangalick, MD, Mycal Mansfield, MD, Henry Mao, MD, Matthew McIff, MD, Mahnaz Qazi, MD, ShaRonda Shaw-Berrocal, DO, Rowena Yu, MD, and Sue Stone, RN.


Dr. J. Jerome Wildgen (AAFP President, 1971-1972) with young patient, circa 1970, from CHFM photograph collections

Claim YOUR Heritage

The Center for the History of Family Medicine is devoted to preserving and sharing the history of family medicine. Through exhibits, research, and reference services, the Center promotes family medicine's distinguished past and looks forward to its promising future. Claim your family medicine heritage.

www.aafpfoundation.org/chfm

AMERICAN ACADEMY OF FAMILY PHYSICIANS FOUNDATION

CENTER FOR THE HISTORY OF FAMILY MEDICINE
CLAIM YOUR HERITAGE

Health IT that puts you in control.

Practical web-based health IT with single sign-on access.

The AMAGINE™ physician portal is the one-stop, web-based solution for your health IT needs. Select from more than 20 industry-leading tools. Start with just one. Or complete your suite with electronic medical records (EMR/EHR), e-prescribing, patient registry, lab ordering and results, or other clinical support tools. All for one low subscription fee. All on one secure website with single sign-on access. Contact us now to assess your priorities, craft a plan, and make health IT work for you. Imagine that.

Call 1 800 262 0411

Email amagine@amagine.com

Visit www.amagine.com/healthITindex

AMAGINE™

How IT should work

Amagine, Inc. is a subsidiary of the American Medical Association.
© 2011 Amagine, Inc.

Quality Improvement. And more.

METRIC integrates practice improvement, evidence-based medicine, and education in a powerful online program that benefits practices, physicians, and patients.

- Evaluate and strengthen practice functions and systems.
- Improve patient outcomes.
- Create real practice applications for CME credit and MC-FP Part IV requirements.

Available METRIC Modules:

Hypertension
Geriatrics
Depression
Asthma
Chronic Obstructive Pulmonary Disease
Coronary Artery Disease
Diabetes

Learn more at:

aafp.org/metric

or call (800) 274-2237

> "METRIC identified specific areas that need attention as we continue to improve the care we provide our patients. It was a very rewarding and educational process."
>
> *David Buck, MD*

METRIC

AMERICAN ACADEMY OF FAMILY PHYSICIANS

Geriatrics, Depression, and Hypertension are supported by an education grant to the AAFP from the AAFP Foundation made possible by The Atlantic Philanthropies. Diabetes, Coronary Artery Disease, and Asthma are supported by an educational grant from Merck. Chronic Obstructive Pulmonary Disease is supported by an educational grant from Boehringer Ingelheim Pharmaceuticals, Inc. and Pfizer, Inc.

EMILY HILL, PA-C

E/M CODING AND THE DOCUMENTATION GUIDELINES:

Putting It All Together

IT'S TIME TO TEST YOUR E/M CODING SKILLS.

Last year *FPM* published a series of articles about the "Documentation Guidelines for Evaluation and Management (E/M) Services," Medicare's attempt to produce a standard, detailed description of the requirements for coding level 1 through level 5 office visits, which are now at the center of almost all payers' auditing and compliance initiatives. The *FPM* articles (listed on page 38) reviewed the guidelines for history, exam and medical decision making and how to use them appropriately. This article provides an opportunity to test your coding acumen by applying what you've learned to two notes, written by family physicians, that represent some of the most common presenting problems in family medicine. This article also includes the documentation guidelines "at a glance" (page 36) and tips to help you more quickly distinguish between level 3 and level 4 visits, which account for so many of the services that family physicians provide (page 35).

CC: Routine follow-up of diabetes and hypertension (established patient)

S: Patient is a 56-year-old female who comes in for follow-up of her type II diabetes mellitus and hypertension. She denies any low blood sugar reactions. Her last A1C was 6.0 percent. She has had a recent eye exam that was normal. She checks her blood pressure (BP) at home once a week and reports that the systolic runs from 130 to 135 mmHg and the diastolic runs from 80 to 85 mmHg. She continues on metformin 500 mg bid, atenolol 50mg qd and baby aspirin qd. She states she is doing well, stays active and continues to work as an administrative assistant.

O: BP 130/80 mmHg. Weight 115 pounds. Chest clear. Cardiac exam reveals regular rate and rhythm without murmurs, gallops or rubs. Extremities have no cyanosis, clubbing or edema.

A/P: 1. Diabetes under excellent control. Continue current regimen. Will check A1C and lipid panel when patient comes back for follow-up. 2. Hypertension under good control. Continue current regimen. 3. Return visit in four to six months.

Stop and think: How would you code this visit?

Discussion. The history involves three components, all of which must be satisfied to determine the level of history overall. Let's start with the history of the present illness (HPI). The 1997 version of the documentation guidelines specifies eight elements that relate primarily to acute problems (location, quality, severity, duration, timing, context, modifying factors, and associated signs and symptoms OR status of chronic diseases). A brief HPI includes documentation of one to three of these elements and is consistent with E/M codes 99212 and 99213. Since this is a follow-up visit for well-controlled chronic conditions, the HPI doesn't meet the level of an extended HPI, which requires documentation of four or more of the elements or the status of three or more chronic diseases. The brief HPI limits the history to problem focused (99212) or expanded problem focused (99213). The review of systems (ROS) is the next component to consider and will influence whether the history meets the requirements for 99212

ADAM NIKLEWICZ

or 99213. Code 99213 requires a problem-pertinent ROS, meaning that only a review of the system directly related to the problem(s) found in the HPI must be documented. In this case, the note addresses blood sugar reactions (endocrine system) and blood pressure readings (cardiovascular system) at home. The note also comments on the patient's recent eye exam, so it can be assumed the physician asked about eye symptoms related to diabetes and hypertension. Some may consider the comments on the patient's well-being ("doing well," "stays active") as review of the constitutional system. Although the review of three or four systems meets the requirements for an extended ROS (2-9 systems), the brief HPI limits the history to expanded problem focused, a level 3 history.

The last history component is the past, family, and social history (PFSH). The patient's current medications (past history) and occupational status (social history) were reviewed. Although these are clinically important, they do not influence the code selection since 99213 does not require documentation of the PFSH.

To test your coding acumen, try coding the two notes in this article before reading the analysis.

Next, let's look at the exam. The 1997 version of the documentation guidelines has been adopted by many family physicians and is the basis for templates in most electronic health record systems (EHRs). We'll look at the 1997 multisystem exam for our review. The Centers for Medicare & Medicaid Services has stated that physicians may use the 1995 version of the guidelines if they prefer. Some payers may permit combining the two versions, for instance by adopting the 1997 guidelines for history, which expanded the definition of an extended HPI to include the review of three or more chronic diseases, with the 1995 guidelines for exam, which depend only on the number of organ systems examined and documented and don't define the content of any exam.

The 1997 version of the E/M documentation guidelines is more commonly used than the 1995 version.

The first exam elements noted are blood pressure and weight. Under the 1997 guidelines, at least three vital signs must be documented to satisfy the requirements for the "Constitutional" exam element. Therefore, while clinically pertinent, the documentation of blood pressure and weight doesn't contribute to the level of the exam. The addition of temperature or pulse rate would have enabled us to consider vital signs for coding purposes.

Some payers allow physicians to combine the two versions of the guidelines.

The note then states "chest clear," which equates to documenting "auscultation of lungs" (one respiratory element). The exam also includes "auscultation of heart" and "examination of extremities for edema and/or varicosities" (two cardiac elements). With three elements documented, the exam is problem focused, which limits the visit code to 99212. To meet the level of exam for code 99213, a minimum of six exam elements (an expanded problem-focused exam) must be documented.

In this example, *medical decision making* will be the determining factor for the level of E/M coding. The decision making elements are the number of diagnosis or management options, the amount and complexity of data reviewed, and the risk of complications, morbidity and mortality. This patient presents with two problems (limited diagnosis/management options), and the physician plans to review two tests (limited data). Prescription medications are involved in the patient's care, which equates to moderate risk despite no changes being made. Although moderate risk is associated with moderate complexity decision making, the diagnosis/management options and data substantiate low complexity decision making. Because two of three components must be met and neither the diagnosis and management options nor the data scores rise to the level of moderate complexity decision making, the documentation supports low complexity decision making.

Putting it all together. Established patient encounters are selected based on two of the three key components (history, exam and medical decision making). In this case, the history and decision making components satisfied the requirements for code 99213.

About the Author

Emily Hill is president of Hill & Associates, a Wilmington, N.C., consulting firm specializing in coding and compliance. Author disclosure: no relevant financial affiliations disclosed.

CC: Shortness of breath (established patient)

S: Patient is a 48-year-old male who presents with a four-week history of intermittent short-

Article Web Address: http://www.aafp.org/fpm/2011/0900/p33.html

THE DIFFERENCE BETWEEN 99213 AND 99214: LESS THAN YOU THINK?

Key components (2 of 3 required, plus medical necessity)	99213	99214	Difference
History	• 1 to 3 HPI elements • review of affected system	• 4+ HPI elements (or status of 3 or more chronic diseases) • review of 2 to 9 systems • 1 PFSH element	• 1 HPI element • review of 1 system • 1 PFSH element
Exam	• 6 to 11 exam elements	• 12+ exam elements	• 1 exam element
Medical decision making	• low risk (e.g., OTC meds) • limited diagnoses or management options	• moderate risk (e.g., prescription meds) • multiple diagnoses or management options	• 1 prescription • 1 established problem that is uncontrolled or 1 undiagnosed problem

ness of breath that has been occurring more frequently over the last week or so. He primarily gets the symptoms at night when he lies down. He states that he has to gasp for breath, but after sitting up for awhile the symptoms usually subside. He is then able to go to sleep without difficulty. He does not get the symptoms during the day, and it is not related to exertion.

He denies cough, nasal congestion, chest pain, abdominal pain and anxiety. He reports frequent eructation and burning. He reports his weight has increased 10 pounds over the last six months. He admits to eating a bedtime snack every night and also drinks large amounts of caffeine, citrus juices and tomato-based products. He had uncomplicated arthroscopic knee surgery five weeks ago and has been taking ibuprofen 800 mg tid until last week when he cut back to 600 mg bid. He has been taking an aspirin a day. He is on no other medications. He does not smoke or use alcohol.

O: BP 120/80 mmHg. Pulse 88. Weight 265 pounds. Patient is well developed and well nourished. Mood and affect are appropriate. Pupils equally round and reactive to light. Pharynx without redness. Thyroid not palpable. Chest clear. Cardiac: normal S1 S2, no murmurs or gallops. Abdomen soft, with mild epigastric tenderness. Liver/spleen not palpable. Active bowel sounds. Skin warm and dry. Extremities without edema or redness. Pedal pulses 2+ bilaterally. ECG: normal sinus rhythm, no acute ST-T wave changes. O2 saturation 98-99%. CXR revealed no abnormalities.

A/P: Probable gastroesophageal reflux disease. Stop all NSAIDs. Tylenol as needed for knee pain. Limit night-time snacks and avoid acid-producing foods. Prilosec OTC 20 mg qd for two weeks. Return to office in two weeks or sooner if no resolution of symptoms. Await formal CXR interpretation.

Stop and think: How would you code this visit?

Discussion. The history includes notations on duration, timing, context, modifying factors and associated signs and symptoms of the present illness. This equates to an extended HPI (four or more elements). The ROS is extended (2-9 systems required), as it includes a review of the respiratory, ENT, cardiovascular, gastrointestinal, psychiatric and constitutional systems. Finally, the note also includes documentation of the past history (surgery and medications) and social history (alcohol/tobacco use). Each of these three areas (HPI, ROS and PFSH) meets the requirements for a detailed history associated with code 99214.

Again, we'll use the 1997 guidelines and the general multisystem exam to evaluate the exam documentation. Three vital signs are noted (one element) as are the general appearance of the patient (one element), eyes (one element), pharynx (one element), examination of the thyroid (one element) and auscultation of lungs (one element). The cardiac exam consists of auscultation, examination of extremities and pedal pulses (three elements). The abdominal exam includes palpation and notation of liver and spleen (two elements). There is a notation of bowel sounds, but this is not included as an exam element in the guidelines. There is also a comment regarding inspection of the skin (one element) and mood and affect (one element). Adding up all these elements results in an examination that

Being familiar with the difference between 99213 and 99214 requirements is important.

The summary (above) of the differences between the two codes can be useful.

NEW PATIENT

Code	History	Exam	Decision Making	Time
99201	PF	PF	S	10 min.
99202	EPF	EPF	S	20 min.
99203	D	D	LC	30 min.
99204	C	C	MC	45 min.
99205	C	C	HC	60 min.
	3 of 3 required			

ESTABLISHED PATIENT

Code	History	Exam	Decision Making	Time
99211	—	—	—	5 min.
99212	PF	PF	S	10 min.
99213	EPF	EPF	LC	15 min.
99214	D	D	MC	25 min.
99215	C	C	HC	40 min.
	2 of 3 required			

History

	HPI elements	ROS systems	PFSH elements
PF	1-3	—	—
EPF		1	—
D	> 3 (OR 3 or more chronic diseases)	2-9	1
C		> 9	2 (estab.) 3 (new)
	3 of 3 required		

HPI: Location, Quality, Severity, Duration, Timing, Context, Modifying factors, Associated signs and symptoms OR Status of chronic diseases

ROS: Constitutional, Eyes, ENT/mouth, Cardiovascular, Respiratory, GI, GU, Musculoskeletal, Skin/breasts, Neurologic, Psychiatric, Endocrine, Hematologic/lymphatic, Allergic/immuno

PFSH: Past, Family, Social history

KEY TO ABBREVIATIONS

ASSMT: Assessment
C: Comprehensive
D: Detailed
EPF: Expanded problem-focused
EX: Examination
HC: High complexity
HPI: History of the present illness
INSP: Inspection
LC: Low complexity
MC: Moderate complexity
PALP: Palpation
PF: Problem-focused
PFSH: Past, family and social history
ROS: Review of systems
S: Straightforward

Exam

	Systems/Areas	Bulleted elements
PF	1+	1-5
EPF	1+	6-11
D	2+	12+
C	9+	18+

Note: For the comprehensive exam, all bulleted elements in the 9+ systems/areas examined must be performed.

General Multisystem Exam

CONSTITUTIONAL
- **Any three** vital signs
- General appearance of patient

EYES
- INSP of conjunctivae & lids
- EX of pupils & irises
- Ophthalmoscopic EX of optic discs & posterior segments

EARS, NOSE, MOUTH & THROAT
- External INSP of ears & nose
- Otoscopic EX of external auditory canals & tympanic membranes
- ASSMT of hearing
- INSP of nasal mucosa, septum & turbinates
- INSP of lips, teeth & gums
- EX of oropharynx: oral mucosa, salivary glands, hard & soft palates, tongue, tonsils & posterior pharynx

NECK
- EX of neck
- EX of thyroid

RESPIRATORY
- ASSMT of respiratory effort
- Percussion of chest
- PALP of chest
- Auscultation of lungs

CARDIOVASCULAR
- PALP of heart
- Auscultation of heart with notation of abnormal sounds & murmurs

EX of:
- Carotid arteries
- Abdominal aorta
- Femoral arteries
- Pedal pulses
- Extremities for edema &/or varicosities

CHEST (BREASTS)
- INSP of breasts
- PALP of breasts & axillae

GASTROINTESTINAL (ABDOMEN)
- EX of abdomen with notation of presence of masses or tenderness
- EX of liver & spleen

- EX for presence or absence of hernia
- EX of anus, perineum & rectum, including sphincter tone, presence of hemorrhoids & rectal masses
- Obtain stool sample for occult blood test when indicated

GENITOURINARY
Male:
- EX of the scrotal contents
- EX of the penis
- Digital rectal EX of prostate gland

GENITOURINARY
Female:
Pelvic EX, including:
- External genitalia & vagina
- Urethra (masses, tenderness, scarring)
- Bladder
- Cervix
- Uterus
- Adnexa/parametria

LYMPHATIC
PALP of lymph nodes in two or more areas:
- Neck
- Axillae
- Groin
- Other

MUSCULOSKELETAL
- EX of gait & station
- INSP &/or PALP of digits & nails

EX of joint(s), bone(s) & muscle(s) of one or more of the following six areas:
1) head & neck; 2) spine, ribs & pelvis; 3) right upper extremity; 4) left upper extremity; 5) right lower extremity; & 6) left lower extremity. The EX of a given area includes:
- INSP &/or PALP with notation of presence of any misalignment, asymmetry, crepitation, defects, tenderness, masses or effusions
- ASSMT of range of motion with notation of any pain, crepitation or contracture
- ASSMT of stability with notation of any dislocation, subluxation or laxity
- ASSMT of muscle strength & tone with notation of any atrophy or abnormal movements

SKIN
- INSP of skin & subcutaneous tissue
- PALP of skin & subcutaneous tissue

NEUROLOGIC
- Test cranial nerves with notation of any deficits
- EX of deep tendon reflexes with notation of pathological reflexes
- EX of sensation

PSYCHIATRIC
- Description of patient's judgment & insight

Brief ASSMT of mental status, including:
- Orientation to time, place & person
- Recent & remote memory
- Mood & affect

Decision making

	Dx/Mx options score	Data score	Risk
S	1 (minimal)	1 (minimal/none)	Minimal
LC	2 (limited)	2 (limited)	Low
MC	3 (multiple)	3 (moderate)	Moderate
HC	4 (extensive)	4 (extensive)	High
	2 of 3 required		

Quantifying risk of complications, morbidity, mortality

Risk Level	Examples
Minimal	**Problems:** One self-limited/minor problem **Dx procedures:** Venipuncture, CXR, EKG, UA, US, echo, KOH prep **Mx options:** Rest, gargles, elastic bandages, superficial dressings
Low	**Problems:** >1 self-limited/minor problem, one stable chronic illness, acute uncomplicated illness/injury **Dx procedures:** Pulmonary function tests, barium enema, superficial needle biopsy, arterial puncture, skin biopsy **Mx options:** OTC drugs, minor surgery (no risk factors), PT, OT, IV fluids w/o additives
Moderate	**Problems:** 1+ chronic illnesses w/ mild Rx side effects; >1 stable chronic illness; new problem, no Dx, (e.g., breast lump); acute illness w/ systemic Sx (e.g., pyelonephritis); acute complicated injury (e.g., head injury w/ brief loss of consciousness) **Dx procedures:** Cardiac stress test, fetal contraction stress test, Dx endoscopy w/ no risk factors, deep needle or incisional biopsy, arteriogram, lumbar puncture, thoracentesis **Mx options:** Minor surgery w/ risk factors, Rx drugs, IV fluids w/ additives, closed Mx of fracture/dislocation w/o manipulation
High	**Problems:** 1+ chronic illnesses w/ severe Rx side effects; potentially life-threatening problems (e.g., acute MI, progressive severe RA, potential threat of suicide); abrupt neuro. change (e.g., seizure, TIA, weakness or sensory loss) **Dx procedures:** Dx endoscopy w/ risk factors **Mx options:** Parenteral controlled substances, Rx needing intensive monitoring for toxicity, DNR decision

Note: For a more complete table of risks, see Medicare's "Documentation Guidelines for Evaluation and Management Services" at http://go.cms.gov/p1QFP5.

would be considered detailed (12+ elements) and satisfies the requirement for code 99214.

Putting it all together. Since only two of the three key components must be met to determine the code for this established patient encounter, the requirements for 99214 are satisfied based on the history and examination. However, medical necessity (as reflected in the medical decision making) always should be considered. According to the *Medicare Claims Processing Manual*, medical necessity is the "overarching criterion for payment in addition to the individual requirements of a CPT code."

Although this patient presents with a single complaint and a differential diagnosis is not explicitly noted, several diagnosis and management options were considered. Some potential diagnoses can be assumed based on the tests ordered (chest X-ray for respiratory and ECG for cardiac). Others might be suggested by the history or derived from experience. For example, in addition to a GI condition, an anxiety or thyroid disorder might also be included in the differential for this patient. This would result in multiple diagnosis/management options. Several diagnostic tests were performed and reviewed (ECG, O2 saturation and chest X-ray) with plans to review a final chest X-ray report (extensive data). Finally, the level of risk may be evaluated based on the fact that over-the-counter medications were prescribed and the patient presented with an acute illness with systemic symptoms that would need to be reassessed within a few weeks (low risk). This combination of components would lead most reviewers to consider the decision making for this encounter to be of moderate complexity. This supposition further supports reporting code 99214 for this encounter.

Once you're familiar with the guidelines, a brief summary like the one on the previous pages can be a good quick reference.

Documentation that would support 99214 for an established patient may support only 99203 for a new patient.

The right clinical templates, history forms and coding tools can ease your coding burden considerably.

RECENT *FPM* ARTICLES ABOUT THE E/M DOCUMENTATION GUIDELINES

These and other articles about E/M documentation from the *FPM* archives can be accessed online at http://www.aafp.org/fpm/medicare.

"Documenting History in Compliance With Medicare's Guidelines." Moore KJ. March/April 2010:22-27.

"Exam Documentation: Charting Within the Guidelines." Moore KJ. May/June 2010:24-29.

"Thinking on Paper: Documenting Decision Making." Edsall RL, Moore KJ. July/August 2010:10-15.

What about new patient encounters?

Levels of service for new patient encounters must meet or exceed the established patient requirements for all three key components. Generally this results in a lower level of service for new patients as compared to established patients even when the documentation is nearly identical. For illustration, imagine the patient in the previous case was new rather than established. The documentation would support coding 99203 for the encounter.

To report code 99204, a comprehensive history and exam must be documented and decision making must be of moderate complexity. For this encounter, the ROS must cover at least 10 systems and a notation about family history must be added. A comprehensive multisystem exam (1997 guidelines) requires documentation of at least two specific elements from each of nine body areas and/or organ systems, and the requirement is not satisfied by this note. By the 1995 guidelines, a comprehensive exam requires that eight or more organ systems be evaluated, which this documentation supports. However, because a comprehensive history was not documented, 99203 is the correct code.

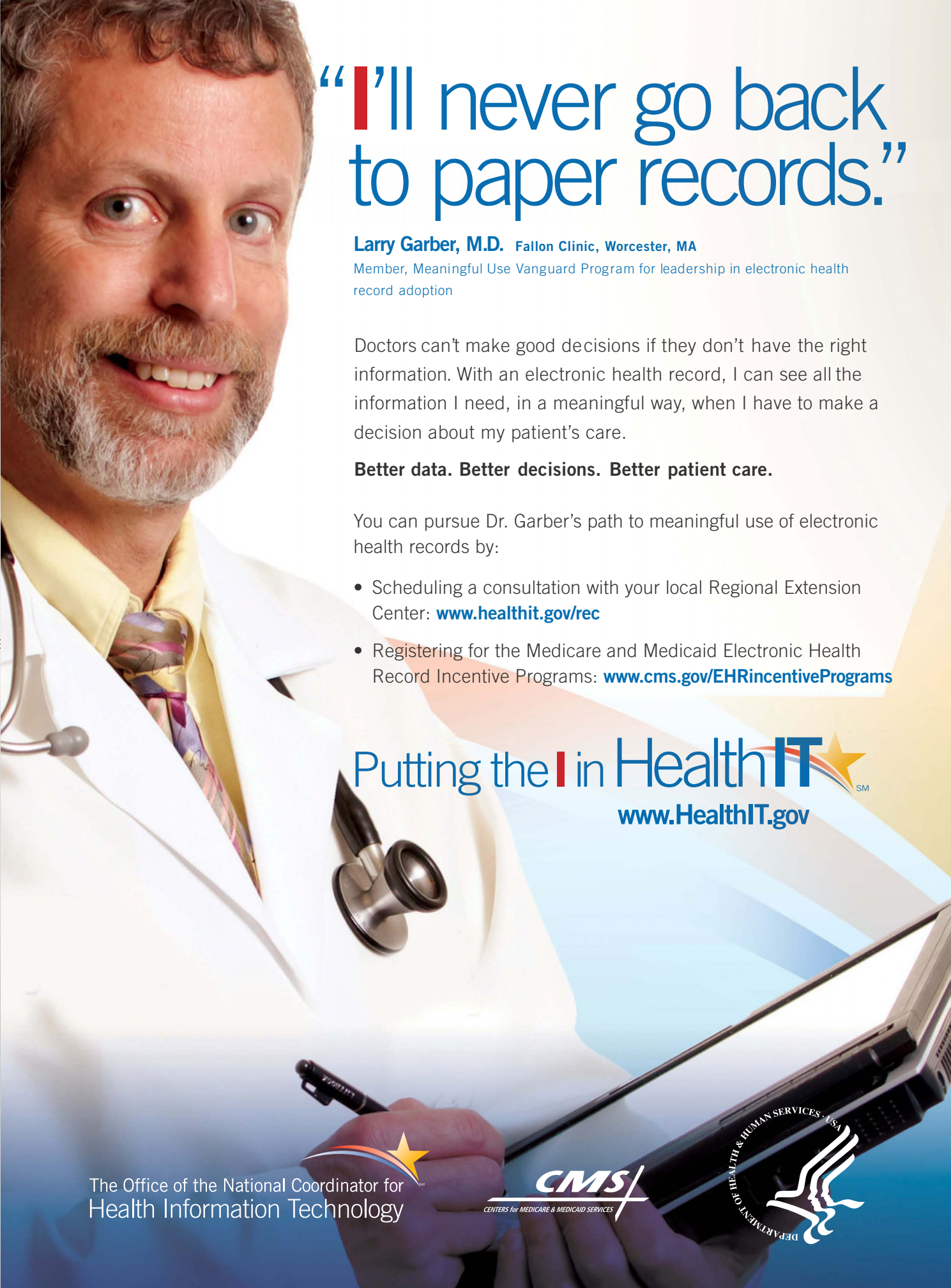
Making it work

It's one thing to audit a clinical note in the quiet of your living room and quite another to choose a level of service during a busy afternoon in the clinic. Using clinical templates, history forms for new patients and coding tools can ease the process of effectively coding and documenting your patient encounters. (The *FPM* Toolbox, at http://www.aafp.org/fpmtoolbox, includes many such resources.)

Many EHRs offer coding suggestions for E/M services. Although this can be a useful tool for checking coding, it should not substitute for the physician's code selection. Depending on the logic built into the EHR, these suggestions may be higher or lower than the encounter warrants.

For most family physicians, simply being familiar with the differences between level 3 and level 4 services will enable you to solve the majority of your daily coding dilemmas. The key is to document carefully and code for what you document. Good luck. FPM

Send comments to **fpmedit@aafp.org.**



"I'll never go back to paper records."

Larry Garber, M.D. **Fallon Clinic, Worcester, MA**
Member, Meaningful Use Vanguard Program for leadership in electronic health record adoption

Doctors can't make good decisions if they don't have the right information. With an electronic health record, I can see all the information I need, in a meaningful way, when I have to make a decision about my patient's care.

Better data. Better decisions. Better patient care.

You can pursue Dr. Garber's path to meaningful use of electronic health records by:

- Scheduling a consultation with your local Regional Extension Center: **www.healthit.gov/rec**
- Registering for the Medicare and Medicaid Electronic Health Record Incentive Programs: **www.cms.gov/EHRincentivePrograms**

Putting the I in HealthIT℠
www.HealthIT.gov

The Office of the National Coordinator for Health Information Technology

CMS CENTERS for MEDICARE & MEDICAID SERVICES

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

Where is my quiz card?

As of July 2011, the paper answer card is no longer included in the print edition of *FPM*. AAFP members and print subscribers can claim AAFP CME credit available through *Family Practice Management* online at **www.aafp.org/fpmquiz**.

Why?

The AMA has changed the criteria for the AMA Physician's Recognition Award credit (*AMA PRA Category 1 credit™*) and now requires learners to demonstrate a level of competency to claim CME credit for journal CME. This change affects all accredited providers, including the AAFP. **To meet this requirement, AAFP journal CME credit must be processed online.**

How?

The AAFP has enhanced its online quizzes to include the additional features needed to meet the new requirement and to make them more convenient for you to complete.

Now you can complete the quiz from your computer, iPhone or Android smartphone, iPad or other web-enabled mobile device and receive instant credit. (If you can't complete the quiz in one session, your answers will be saved and you can finish later.)

What about past issues?

Printed quiz cards published before July 1, 2011, will continue to be accepted for approximately one year following the date of publication.

Where do I start?

Go to **www.aafp.org/fpmquiz** and log in to see the list of quizzes available. Detailed log-in instructions are provided online, including links to help you retrieve your username and password. If this is your first time logging in to the AAFP web site, you'll need your AAFP member number or the ID number from your *FPM* address label.

From here, you can take the quiz and claim your credit.

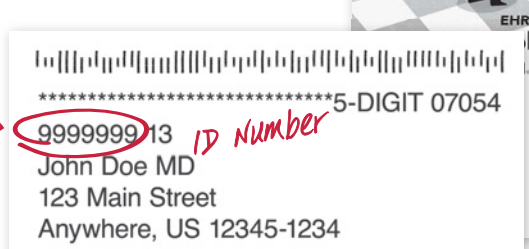
Questions?

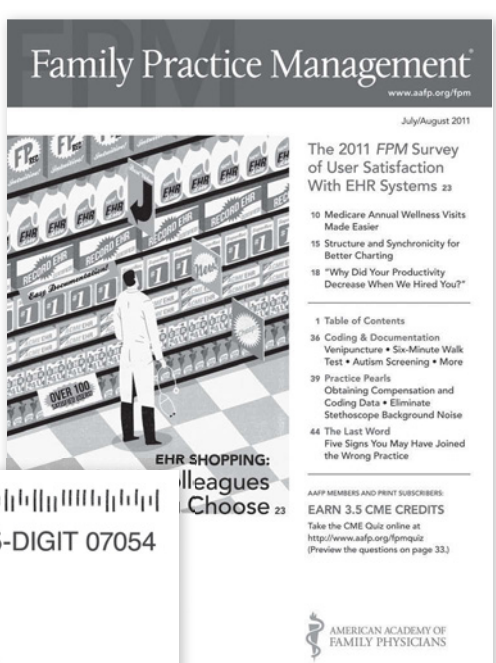
Email us at contactcenter@aafp.org or call (800) 274-2237.

Complete quizzes online to confirm your knowledge and receive credit instantly.

Ready to take the quiz?

Go to www.aafp.org/fpmquiz and log in as usual. If you've never logged in to the AAFP web site, you will need your AAFP member number or the 7 digit number that appears above your name on your *FPM* address label.





See page 40 for info about quiz changes.

CME QUIZ

AAFP credit

Family Practice Management has been reviewed and is acceptable for up to 20 Prescribed credits by the American Academy of Family Physicians. AAFP accreditation begins Oct. 1, 2010. Term of approval is for one year from this date.

This issue is approved for up to 3.25 Prescribed credits. Credit may be claimed for one year from the date of this issue. Total credit is subject to change based on additional issue topic submissions.

The AAFP is accredited by the Accreditation Council for Continuing Medical Education to provide CME for physicians.

AAFP members may obtain the designated number of Prescribed credits for the year in which the online quiz is completed.

AMA/PRA Category 1 credit

The AAFP designates this educational activity for a maximum of 3.25 AMA/PRA Category 1 Credits. Physicians should only claim credit commensurate with the extent of their participation in the activity.

AAFP members who satisfy the Academy's CME requirements are automatically eligible for the AMA/PRA. Nonmember physicians and health care professionals are eligible to receive the designated number of AMA/PRA Category 1 Credits on submission of the online quiz. The AAFP keeps a record of AMA/PRA Category 1 Credits for nonmember physicians and health care professionals; however, these individuals are responsible for reporting their own Category 1 CME credits when applying for the AMA/PRA or other certificates or credentials. See the instructions below for information about letters of participation.

AOA Category 2 credit

CME activities approved for AAFP credit are recognized by the American Osteopathic Association as equivalent to AOA Category 2 credit.

Instructions

You must be an AAFP member or a subscriber to *FPM* in print to earn CME credit. Read the articles covered by the quiz, answer the questions, then check your answers against the correct answers given. Let any wrong answers guide further review of the articles. Complete the quiz online at http://www.aafp.org/fpmquiz. **Note: This quiz is not valid for CME credit after Oct. 31, 2012.**

AAFP members: You may print your CME transcript at http://www.aafp.org/myacademy.

Nonmember subscribers to *FPM* in print: You may print a letter of participation at http://www.aafp.org/cmecertificate. Log in using your subscriber ID number, the 7-digit number printed above your mailing address on this issue. You are responsible for reporting your CME credits to any third parties.

Questions? Call the AAFP Contact Center: 800-274-2237.

AAFP Members and *FPM* Subscribers: Click here to take the quiz now

SEPTEMBER/OCTOBER 2011 CME QUIZ

Type-A Questions
(Each has only one right answer.)

What Family Physicians Need to Know About ACOs (p. 17)

Q1. Of the five key functions of an accountable care organization, which one is the most important, and perhaps most difficult, according to the article?

- ❑ A. Creating a culture of teamwork, shared commitment and clinical integration.
- ❑ B. Establishing financial incentives.
- ❑ C. Measuring performance.
- ❑ D. Implementing best practices.
- ❑ E. Engaging patients.

One Last Annual ICD-9 Update (p. 24)

Q2. Which new obstetric code identifies when a patient has a personal history of gestational diabetes?

- ❑ A. V23.42
- ❑ B. V23.87
- ❑ C. 631.0
- ❑ D. V12.21
- ❑ E. 631.8

Remove Roadblocks and Improve Access to Preventive Care (p. 26)

Q3. Which of the following was *not* part of the practice's effort to incorporate well-child care into acute care visits?

- ❑ A. Assessing the percentage of patients who had been seen for acute care but weren't up-to-date on well-child care.
- ❑ B. Determining whether well-child care and acute care services could be billed when provided at the same visit.
- ❑ C. Teaching physicians how to document and code the visits.
- ❑ D. Adding 10 minutes to all pediatric acute care appointment slots.
- ❑ E. Using a different physician for each part of the visit.

E/M Coding and the Documentation Guidelines: Putting It All Together (p. 33)

Q4. Which of the following describes the key difference between the 1995 and 1997 guidelines related to documenting history?

- ❑ A. The number of ROS elements required to support a detailed history is higher in the 1997 guidelines.
- ❑ B. Documenting the status of three or more chronic diseases supports a detailed history in the 1997 guidelines.
- ❑ C. The 1997 guidelines give greater emphasis to the past, family and social history.
- ❑ D. The 1997 guidelines are abbreviated.
- ❑ E. The 1995 guidelines give less weight to the level of history than to the levels of exam and medical decision making.

Coding & Documentation (p. 45)

Q5. Which of the following describes the best way to code and bill for a visit at which the physician provides a steroid injection for shoulder impingement, diagnoses eczema and prescribes a topical calcineurin inhibitor?

❑ A. Code the injection and the office visit with modifier 25.
❑ B. Code the injection and the office visit with modifier 59.
❑ C. Code the injection only.
❑ D. Code the office visit only.
❑ E. Code the injection with a prolonged services code for the portion of the visit devoted to the patient's eczema.

Type-X Questions (Each may have more than one right answer.)

What Family Physicians Need to Know About ACOs (p. 17)

Q6. Which of the following are among the key requirements to success for an accountable care organization?

❑ A. Large-scale physician employment.
❑ B. A critical mass of patients to generate sufficient savings.
❑ C. A strong base of high-performing primary care physicians.
❑ D. Substantial financial incentives to help change physician behavior.

Remove Roadblocks and Improve Access to Preventive Care (p. 26)

Q7. What changes did the practice described in the article make to improve the percentage of Medicaid patients receiving well-child checks?

❑ A. They reduced restrictions on appointment availability for preventive care.
❑ B. They began providing well-child care to patients at the same time they were seen for acute care.
❑ C. They hired an RN to focus on the problem.
❑ D. They used monthly member reports provided by a key health plan to identify patients in need of well-child care, and then contacted their parents or guardians to schedule appointments.

E/M Coding and the Documentation Guidelines: Putting It All Together (p. 33)

Q8. Which of the following statements is true regarding the status of the 1995 and 1997 versions of the "Documentation Guidelines for Evaluation and Management Services," according to the article?

❑ A. The 1997 guidelines are more widely used than the 1995 guidelines.
❑ B. Physicians may use either version of the guidelines.
❑ C. Some payers permit combining the two versions, for example, by using the 1997 guidelines for history and medical decision making and the 1995 guidelines for exam.
❑ D. The 1995 guidelines for exam focus on the number of organ systems examined, while the 1997 guidelines define the content of the exam.

Quality Improvement Survey

Q9. Which of the following articles in this issue provided information that you found useful?

❑ A. From the Editor: The RUC Under Fire (p. 10)
❑ B. Opinion: The EHR Incentive Program: Consider Waiting for Next Year (p. 14)
❑ C. What Family Physicians Need to Know About ACOs (p. 17)
❑ D. One Last Annual ICD-9 Update (p. 24)
❑ E. Remove Roadblocks and Improve Access to Preventive Care (p. 26)
❑ F. E/M Coding and the Documentation Guidelines: Putting It All Together (p. 33)
❑ G. Coding & Documentation (p. 45)
❑ H. Practice Pearls (p. 47)
❑ I. The Last Word: A Life Checkup (p. 52)

Q10. How would you rate *FPM* in terms of the clarity of the information presented?

❑ A. Excellent.
❑ B. Good.
❑ C. Neutral.
❑ D. Fair.
❑ D. Poor.

Q11. Thinking of all the issues of *FPM* you have seen recently, please rate the overall quality of *FPM* as a vehicle for CME in the nonclinical aspects of practice.

❑ A. Excellent.
❑ B. Good.
❑ C. Neutral.
❑ D. Fair.
❑ D. Poor.

Q12. Has anything you have read in the last few issues of *FPM* led you to change anything in your practice?

❑ A. Yes.
❑ B. No.

We would appreciate your suggestions for improving the CME experience offered through *FPM*. See page 9 for contact information.

WANT TO EARN MORE CME CREDITS?

AAFP members can earn **2 additional CME credits** per issue by completing the Translation to Practice activity.

For instructions, visit the online quiz:
http://www.aafp.org/fpmquiz.

Answers to the September/October 2011 Quiz

Q1. A	**Q4. B**	**Q7. A, B, D**
Q2. D	**Q5. A**	**Q8. A, B, C, D**
Q3. E	**Q6. B, C, D**	

AAFP PRESCRIBED CREDIT AVAILABLE!

The more your patients expect from you, the more you need UpToDate®.

Some professionals change roles over the course of a career. You do it in a single visit. But when it comes to being an interpreter of medical information, over 400,000 clinicians worldwide rely on UpToDate and its complete, evidence-based coverage of 16 specialties. In fact, in the US alone, family physicians perform over 4.5 million searches in UpToDate each year. Our staff of world-renowned doctors has created this unbiased, easy-to-use electronic resource to provide you with the answers you need for your most important role: trusted physician.

14-day Free Trial for AAFP Members learn.uptodate.com/AAFP

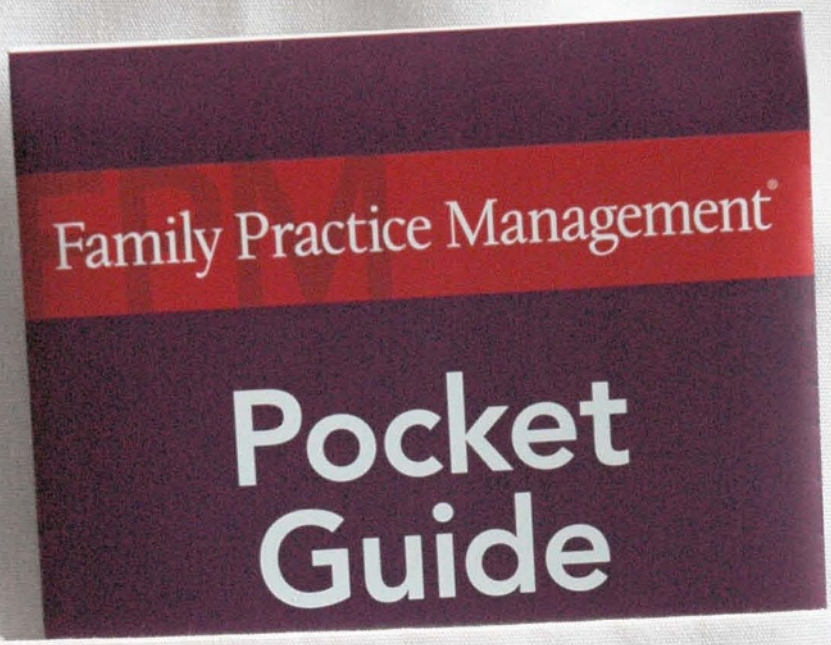
For more information, call 1-888-525-1299 or +1-781-392-2000.

Wolters Kluwer Health | UpToDate

Recommended by:

AMERICAN ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

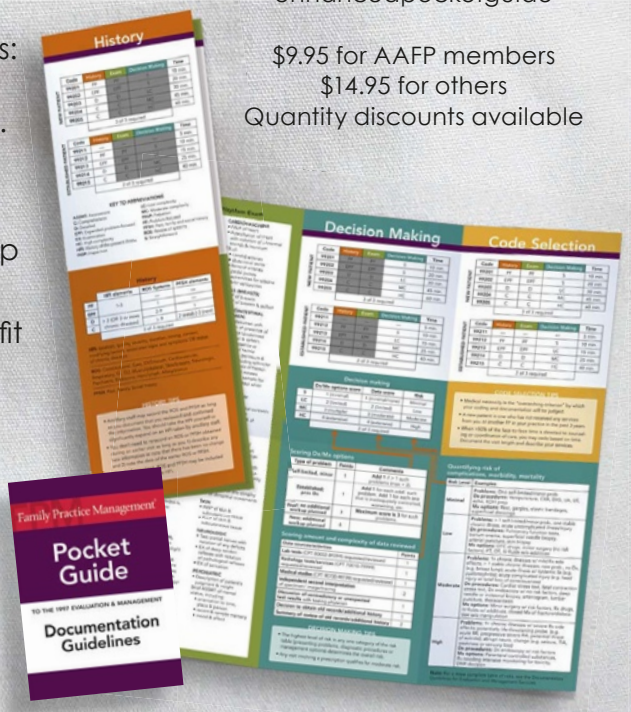
Put a wealth of coding help in your pocket.



Order *FPM*'s enhanced Pocket Guide to the E/M Documentation Guidelines.

Family Practice Management's most popular coding tool is available in a **new, improved format** with these added features:

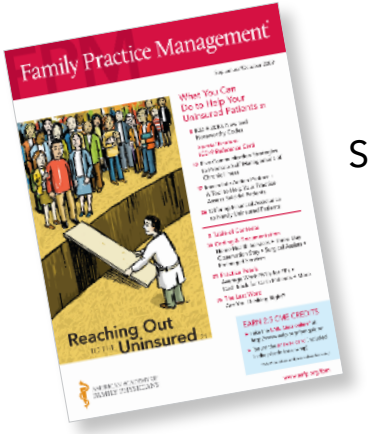
- Valuable documentation tips.
- Key information organized by color.
- Synthetic paper that stands up to long-term use.
- And a more compact size to fit your pocket!



Call 1-800-944-0000 or visit www.aafp.org/fpm/enhancedpocketguide

$9.95 for AAFP members
$14.95 for others
Quantity discounts available

AMERICAN ACADEMY OF FAMILY PHYSICIANS



Who says you can't take it with you?

Subscribe (www.aafp.org/fpm/subscribe) to the print edition of *FPM* and you can take it with you wherever you go.

Plus...

Family Practice Management®

AAFP Members, you get the convenience of a print journal for a mere 5 bucks an issue.

Nonmembers, you get full access to *FPM* online *and* the opportunity to earn 20+ free CME credits a year.

Subscribe today.

www.aafp.org/fpm/subscribe

Family Practice Management®

CODING & DOCUMENTATION

Cindy Hughes, CPC

Joint injection + E/M service?

Q I was taught that for injections of major joints such as the knee or shoulder, insurance companies generally will pay for an office visit or the injection (CPT code 20610) but not both. For example, if a patient comes in with impingement syndrome of the shoulder and I do a steroid injection, I customarily code 20610 plus the CPT code for the corticosteroid medication administered – omitting the office visit code because the injection code pays more. Is this the best approach?

A The joint injection codes are assigned a zero-day global period, which means that an evaluation and management (E/M) service should not be billed on the same date. This is because the procedure was valued to include the initial assessment and other pre-service work. However, when the E/M service is significant and separately identifiable from the typical pre-service work of providing the injection, the E/M service may be separately reported with modifier 25 attached. An E/M service should not be billed for a planned injection service where the patient presents with no complication or new problem.

Your Medicare Administrative Contractor and private payers may provide additional guidance on this subject. For instance, Cigna Government Services and Trailblazer Health have published guidance that says providers are allowed to bill for an appropriate E/M service if they decide to start the series of injections after evaluating the patient during the same visit and their documentation supports the level of E/M service billed.

Annual wellness visits and Part D vaccines

Q Tdap and herpes zoster vaccines are indicated for Medicare patients but are not among the elements Medicare considers part of the annual wellness visit. What is the best approach to providing and billing for these vaccines?

A These vaccines are covered only under Medicare Part D prescription plans. You can either provide the patient with a prescription to receive these from a pharmacy that participates with the patient's Part D plan, sign up to be a provider of Part D vaccines and receive payment directly, or provide the vaccines as an out-of-pocket cost to the patient and provide the patient a claim form to submit to the Part D plan for any benefits payable for out-of-network services. (More information is available on the AAFP web site at http://bit.ly/qPWLKC.)

The Centers for Medicare & Medicaid Services (CMS) have developed a quick reference chart for the annual wellness visit that may be helpful: http://www.cms.gov/MLNProducts/downloads/AWV_Chart_ICN905706.pdf.

Newborn heel stick

Q What is the CPT code for a heel stick for a bilirubin and PKU on a newborn?

A It is 36416, "Collection of capillary blood specimen (e.g., finger, heel or ear stick)." This code is also often reported in conjunction with screening for lead. Medicare has assigned this code a "B" status, meaning it is always bundled with other services on the same date, but many Medicaid plans provide separate payment due to state mandates for lead screening in children. Private payers may or may not bundle this with other services on the same date; check with those you contract with.

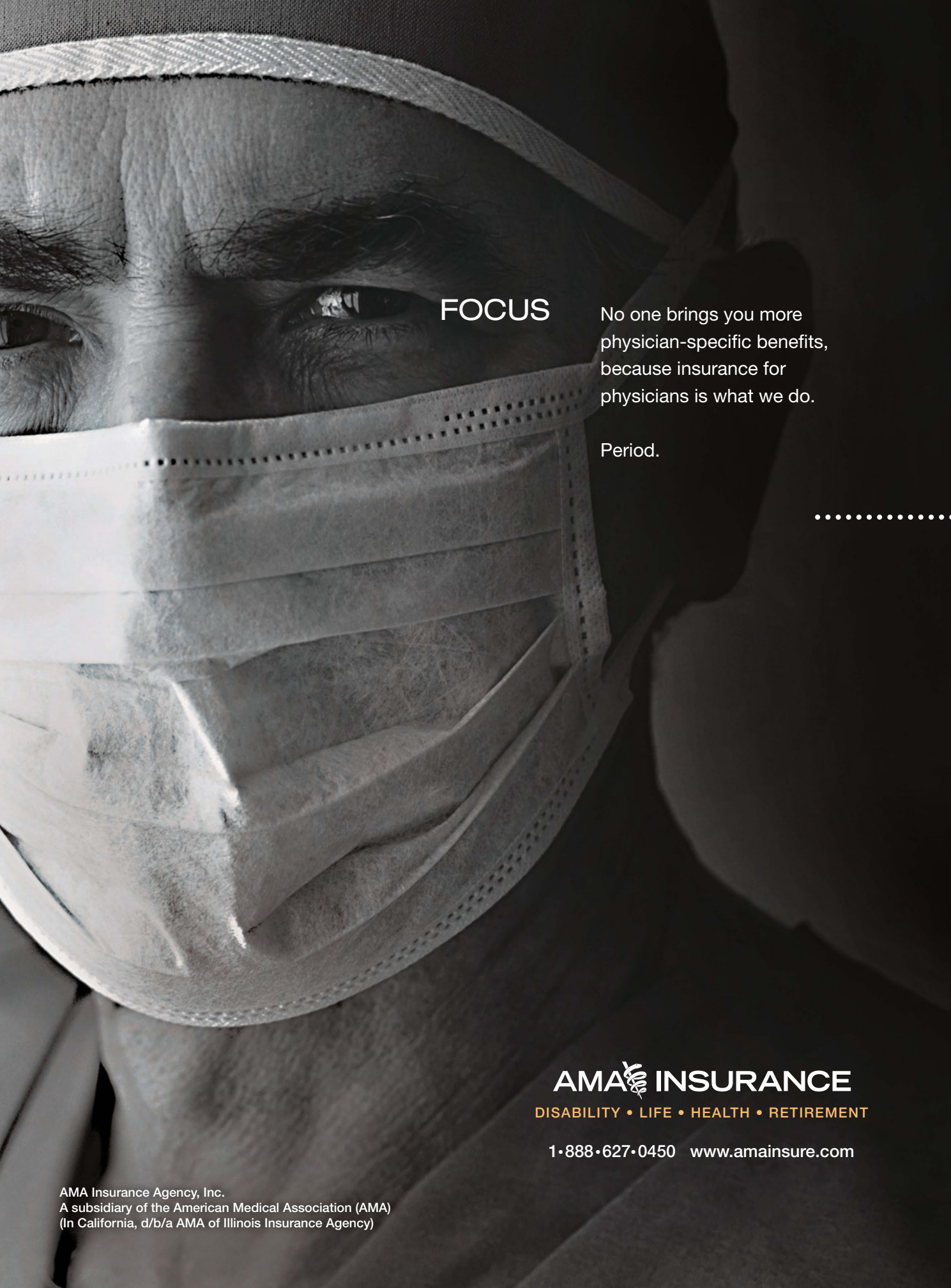
Editor's note: While this department attempts to provide accurate information, some payers may not agree with our advice. You should refer to the current CPT and ICD-9 coding manuals and payer policies. FPM

About the Author

Cindy Hughes is the AAFP's coding and compliance specialist and is a contributing editor to *Family Practice Management*. Author disclosure: no relevant financial affiliations disclosed. These answers were reviewed by the *FPM* Coding & Documentation Review Panel, which includes Robert H. Bösl, MD, FAAFP; Marie Felger, CPC, CCS-P; Thomas A. Felger, MD, DABFP, CMCM; David Filipi, MD, MBA, and the Coding and Compliance Department of Physicians Clinic; Emily Hill, PA-C; Kent Moore; Joy Newby, LPN, CPC; P. Lynn Sallings, CPC; and Susan Welsh, CPC, MHA.

DO YOU HAVE A CODING OR DOCUMENTATION QUESTION?

Send it to *FPM* by e-mail, **fpmedit@aafp.org**; by mail, *Family Practice Management*, 11400 Tomahawk Creek Parkway, Leawood, KS 66211-2680; or by fax, 913-906-6010. Include your address, daytime phone number and fax number. We cannot respond to all questions we receive, but we will publish answers to selected questions.


FOCUS
No one brings you more physician-specific benefits, because insurance for physicians is what we do.
Period.
AMA INSURANCE
DISABILITY • LIFE • HEALTH • RETIREMENT
1•888•627•0450 www.amainsure.com
AMA Insurance Agency, Inc.
A subsidiary of the American Medical Association (AMA)
(In California, d/b/a AMA of Illinois Insurance Agency)

Disability Pro℠

Own-Occupation Disability Insurance for Physicians with:

- Benefits designed specifically to meet the needs of physicians
- Benefits payable up to $12,500 a month, directly to you
- A completely portable plan and benefits that can be tax-free

For a personalized quote today, call

1•888•627•0450

or for more information go to amainsure.com /disabilitypro

Streamline processes when using an EHR

Adopting an electronic health record system (EHR) posed many challenges for our practice. To address these, we've employed several useful tactics:

Messaging. The nurse accesses the inbox for labs, X-rays, etc., and she filters and manages the majority of the messages. If a message requires physician action, the nurse brings it directly to the physician. We find that verbal messaging between nurse and physician is much more efficient than a series of electronic messages. We don't automatically transfer all incoming information to the physician; we believe that the doctor needs information "just in time" – not "just in case" or "just because we can."

Documentation. I dictate in the exam room with the patient, following the motto "Do everything you do for the patient in front of the patient." This saves me time and increases face-to-face contact with the patient. I also use electronic templates that include check boxes for exam elements, standard chronic illness questions, etc. Common combinations are preselected to help us minimize clicks when appropriate.

Results reporting. By proactively planning appointments and getting lab work completed before office visits, we can report 95 percent of results to our patients during their encounters. This eliminates the need to pull up the record and reconstruct the patient's scenario a few days later and make decisions out of context. It also eliminates the need to report the results over the phone. This approach saves at least an hour per day, improves patient communication and facilitates shared decision making. The nurses print copies of lab and X-ray results, which I use during the appointment and then give to the patient. It is much faster for me to review the results when consolidated on one piece of paper than when I have to navigate through all of the screens and slow downloads.

Prescriptions. We renew all maintenance medications for 15 months at the time of the annual comprehensive care visit. The physician authorizes the refill on a printed medication list and then the nurse electronically sends the script to the pharmacy. This eliminates the majority of refill requests and saves a half-hour to an hour of staff time each day.

Patient flow. We've found that having three exam rooms and two clinical assistants helps with patient flow. We also ask patients to complete a pre-appointment questionnaire. To streamline documentation, patients who are being seen for a Medicare annual wellness visit (AWV) complete most of the required information on an AWV-specific form that mirrors our EHR templates, making data entry easier.

Order entry. We do not ask our physicians to work through a long series of check boxes in the EHR to enter orders. Instead, we developed a concise paper checklist that the doctor completes. The patient then takes the checklist to the receptionist, who enters the orders into the computer and schedules any follow-up. We also follow standing orders for common scenarios to minimize unnecessary information flow in the office.

Christine A. Sinsky, MD, FACP
Dubuque, Iowa

FPM

HELP US HELP YOU

Practice Pearls presents the best advice on effective, efficient practice operations and patient care. Send your best pearl (250 words or less) to fpmedit@aafp.org, and if we publish it, you'll earn $25.

The Family Practice Management Classified Department can assist you with your advertising needs. For information on the "Family Buy" Discount Program with *Family Practice Management* and *American Family Physician*, please contact: (800) 237-7027; Fax: (727) 445-9380; E-mail: fpm@russelljohns.com.

Physicians Wanted

BENEWAH MEDICAL CENTER AND WELLNESS Center - family medicine staff physician, full-time. FQHC/I.H.S. outpatient facility located on the Coeur d'Alene Indian Reservation in Plummer, Idaho. Competitive salary and benefit package; Monday-Friday 8:00 am – 6:00 pm clinic. Seeking ABFM certified MD/DO with five years experience. Beautiful rural community minutes from Lake Coeur d'Alene perfect for outdoor enthusiasts, yet 40 minutes from Spokane, Wash. and Coeur d'Alene, Idaho. No call, no weekends. For more information contact Tim Horlacher, HR Director at: (208) 686-5071; or hr@bmc.portland.ihs.gov.

GREAT OPPORTUNITY FOR BOARD CERTIFIED/ board eligible family medicine or med peds physician without OB at Memorial Hospital in Chester, Illinois. One hour south of St. Louis. Competitive employment compensation with signing bonus, paid vacation, holidays, CME time off with allotment. Includes health insurance, deferred compensation, pro-liability insurance, dues, subscriptions, etc. Monthly stipend and student loan repayment options available. Contact Steve Hayes, Administrator at: (618) 826-7228 or www.mhchester.com.

MISSOURI COLLEGE COMMUNITY. OUTPATIENT only, one hour to Kansas City/Columbia. Join seven physician group. Salary, bonus, benefits and partnership. $250,000 - $300,000 income expectation. (800) 831-5475; E-mail: donohueandassoc@aol.com.

Physicians Wanted

THRIVING URGENT CARE PRACTICE LOCATED IN beautiful Roswell/Alpharetta, Georgia seeking full-time and part-time physicians and mid-levels to work in urgent care setting. Candidates must be board certified in primary care or emergency medicine and must have a minimum of three years in ED, urgent care or family practice. Please e-mail CV to: sharrison@qps-ga.com attention: Urgent Care Position.

PHYSICIAN (FAMILY PRACTICE). FULL-TIME positions available immediately at Blanchfield Army Community Hospital, Ft. Campbell, Kentucky. Multiple positions available. Benefits include 10 paid holidays, annual and sick leave, Thrift Savings (401K), retirement, health and life insurance. Recruitment bonus and relocation assistance available. Please contact Human Resources Division at: (270) 798-8009. The Federal Government is an EOE.

Physicians Wanted

MAGNOLIA MEDICAL CLINIC IN FORT WALTON BEACH

Located near the beautiful beaches of Northwest Florida. We are seeking a board certified family physician. We provide a full spectrum of family medicine, including inpatient care, without obstetrics. Our four physician clinic has a full-service Lab and an X-ray department, including Dexa Scan. Earnings are in the top 5–10 percentile in the U.S. Partnership potential.

Please call or email your interest to Peter K. Senechal, MD at: (850) 243-7681 • recruiting@mmcfp.com

Online Job Board for Family Physicians

Sign Up for **FREE** to:

• Search & Apply to Jobs Online • Upload Your Resume
• Save Jobs of Interest • Receive New Jobs Via Email

American Family Physician | Family Practice Management | CAREERCENTER

www.AFPCareerCenter.com

MOUNT CARMEL

COLUMBUS, OHIO
Mount Carmel Healthcare
ASSOCIATE PROGRAM DIRECTOR
Family Medicine Residency

Mount Carmel, one of the largest health care systems in central Ohio, is seeking an Associate Program Director for its ACGME-accredited Family Medicine Program. The Family Medicine Residency includes 18 residents, and offers an excellent training platform for inpatient care, outpatient clinics, newborn care, OB, and education. The Associate Program Director will assist in providing general oversight with the planning, development and coordination of the resident educational program.

Please consider this advantage:
• The inpatient residency training takes place at Mount Carmel St. Ann's, a community – based hospital, which provides residents with an unopposed learning environment.

The successful candidate must be board-certified and have teaching experience, clinical experience and leadership skills.

For more information, contact Julie Hotchkiss:
(614) 546-4398 • Fax: (614) 546-4946
jhotchkiss@mchs.com
Not an H1 or J-1 opportunity

Saint Alphonsus Medical Group

FAMILY MEDICINE

Move here for Quality of Life to enjoy the outdoors, natural beauty, world renowned fishing, hiking and biking in family friendly communities.

Requirements:
- Board Eligible/Board Certified MD or DO
- ACGME or AOA approved residency-trained in primary care field
- Must obtain medical license in both Oregon and Idaho

We Offer:
- Competitive compensation and benefits
- Student loan repayment
- Hospital-based employment
- Clinic-based primary care practice in Fruitland, ID or Baker City, OR
- Flexible scope of practice supported by mid-levels

To learn more, visit: www.saintalphonsus.org/careers-video.html

Please contact:
Michael Gibbons at (800) 309-5388
Send CV to michgibb@sarmc.org or fax to (208) 367-7964

Physicians Wanted

Board Certified Family Physician Needed

Missouri Ozarks Community Health, a Federally Qualified Health Center located in Ava, MO is seeking a board certified family medicine physician or internist who desires to practice comprehensive outpatient medicine free of the financial constraints of private practice.

Position Offers:

- Competitive Salary • Loan repayment, sign-on bonus and moving expenses
- Health, dental and vision plans
- Life Insurance • 401K Plan
- Malpractice Coverage
- CME/Licensure Allowance
- Vacation/Personal Time
- Monday-Friday work week with no weekend or evening call

Ava, MO is located an hour away from Springfield and Branson, MO. Numerous outdoor activities available with many lakes, streams and rivers located nearby. Springfield and Branson offer many entertainment options. Quiet, peaceful community setting offering a great practice opportunity! Site qualifies for NHSC loan repayment as well as state loan repayment. MOCH is a newly constructed medical facility with all new equipment and electronic medical records.

Please Contact Jennifer Heinlein directly at: (417) 683-4831 ext. 111 for more information or by E-mail at: jheinlein@moch.us.

Serving YOUR Family Health Care Needs

Medical Services

LOW COST BLOOD TEST BY COURIER

CBC and Chem Panel $10.00
PSA $15.00
HIV Screen $15.00 and more
CLIA registered and Medicare approved laboratory
Telephone: (866) 505-1556
Web: www.LowCostBloodTest.Org

Find the Right Job

American Family Physician Family Practice Management | CAREERCENTER

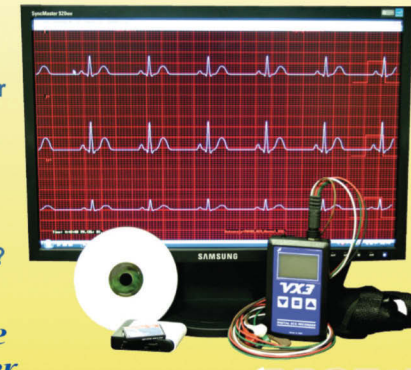
www.AFPcareercenter.com

Medical Equipment

Are you using a Holter Service or Referring out your Holter?

Our digital, PC-based Holter System can increase revenue, save time and expedite patient treatment.

Reimbursement Info: At $200 reimbursement under CPT Code 93230, the system pays for itself within a month or two! Indications include these approved ICD-9 codes: 780.2 Syncope, 785.1 Palpitations, 786.50 Chest Pain, and many others. How many of these patients do you see per month?



If you are using a Holter Service you are losing at least $100 per Holter, AND you have to wait for results.

Was $4,995 NOW Too LOW to Advertise!

877-646-3300 • www.medicaldevicedepot.com

Call us! We will show how our State of the Art Holter System can benefit your practice.

Online Job Board for Family Physicians

Sign Up for **FREE** to:

- Search Jobs
- Apply to Jobs Online
- Save Jobs of Interest
- Upload Your Resume
- Receive New Jobs Via Email

American Family Physician Family Practice Management | CAREERCENTER

www.AFPcareercenter.com

smartphone scan

EKG Machines at Rock Bottom Prices!

Medical Device Depot sells the best name brands at the lowest prices!

Our machines come with a long-term warranty and in-office training. Choose from the following special deals:

See before you buy!!
Trade-ins Welcome!!

AT-1i: Multi-channel EKG w/interpretation ~~$2,477~~ **$1,398**

AT-2i: Multi-channel EKG w/interpretation & full page printout ~~$3,277~~ **$1,856**

AT-2 light: Multi-channel EKG w/interpretation, full page printout & alphanumeric keyboard ~~$3,645~~ **$2,275**

3 YEAR WARRANTY
AT-2 plus combo, EKG w/Spirometry pictured

AT-2 plus: Multi-channel EKG w/interpretation, full page printout, alphanumeric keyboard & EKG waveform display ~~$3995~~ **$2,677**
Add spirometry for **$1,000**

Pulse Oximeters from **$199** -Spirometers **$350-$2500** - PC Based EKG **$1800** - Stress Test Systems **$2995** - PC Based Holter System **$2900** - Ambulatory BP Monitors - Vital Signs Monitors from **$300** - Dopplers from **$395** - Refurbished Ultrasounds

Call for on-site demonstration or more info!

877-646-3300 • www.medicaldevicedepot.com

Practices Available

WWW.DOCTORSBROKER.COM. FAMILY MEDICINE practices available in Georgia and Florida. Practices wanted in Florida. Call: (407) 252-5276.

NATIONAL

SELLING A PRACTICE?
Buying a Practice? Buying into a practice?
Appraising the Market Value of your Practice?
Setting up for a Sale or Purchase?
Looking for a Buyer or Seller?

I represent physicians selling their practices who are considering retiring or relocating. I also represent physicians who are interested in appraising and evaluating practices they have found themselves.

In either case, all the details of your specific practice transfer can be arranged in all specialties of medicine and surgery. During the past 30 years, I have appraised and sold hundreds of practices throughout the U.S. Should you need to find a prospective purchaser for your practice, I can provide that service.

If you would like to be fully prepared for a sale, purchase or buy-in, and require an experienced consultant, representing your interests in a tactful and professional manner, I would be pleased to hear from you.

See Website Below For Listing of Practices For Sale.
For Further Information Contact:
Gary N. Wiessen
Phone: 631-281-2810 • Fax: 631-395-1224
E-mail: gnw1@buysellpractices.com
Web site (including credentials):
www.buysellpractices.com

Want to place an ad?
Need a quote?
Email to:
fpm@russelljohns.com

Transcription Services

Medical Transcription

- 6.9 cents per line
- 99.5% accuracy guaranteed
- 10,000 lines or 1 week free trial
- No start-up costs, no minimums
- Same day turn around guaranteed
- 2 hours turn around for stat files
- Transcripts to referral doctors same day
- Templates and macros welcome
- Call-in toll free dictation included
- HIPAA compliant

CALL (888) 50-AAAMT, Fax (888) 51-AAAMT
or E-mail to: info@aaamt.com

Visit www.AAAMT.com

FAMILY PRACTICE MANAGEMENT

Family Practice Management ranks #1 among non-clinical journals for reaching office-based, family medicine readers.

(800) 237-7027
(727) 443-7667
Fax: (727) 445-9380

Family Practice Management

Why FPM?

"I would not be able to manage being in a practice without your magazine."

THE PLACE TO BE to fulfill your recruitment, product and services advertising needs.

(800) 237-7027
(727) 443-7667
Fax: (727) 445-9380
fpm@russelljohns.com

For information regarding advertising in the *FPM* Marketplace, please contact 800-237-7027 or fpm@russelljohns.com.

Family Practice Management

3 ways to get Family Practice Management

Visit our Web site*
www.aafp.org/fpm

Subscribe to the print edition
www.aafp.org/fpm/subscribe

Sign up for our free digital edition
www.aafp.org/fpm/digitalfpm

*Full access for print subscribers and AAFP members; archive access for all others.

UpToDate®

Answer your clinical questions quickly with *UpToDate®*

14-Day Free Trial — Just for AAFP Members
www.uptodate.com/trial/aafp

Recommended by:
American Academy of Family Physicians
Strong Medicine for America

Research essential to family medicine

The Annals of Family Medicine, a peer-reviewed clinical research journal, is dedicated to advancing knowledge essential to understanding and improving health and primary care. View the full content online at www.AnnFamMed.org, or order your print subscription online or by calling 1-800-274-2237, Ext. 5165.

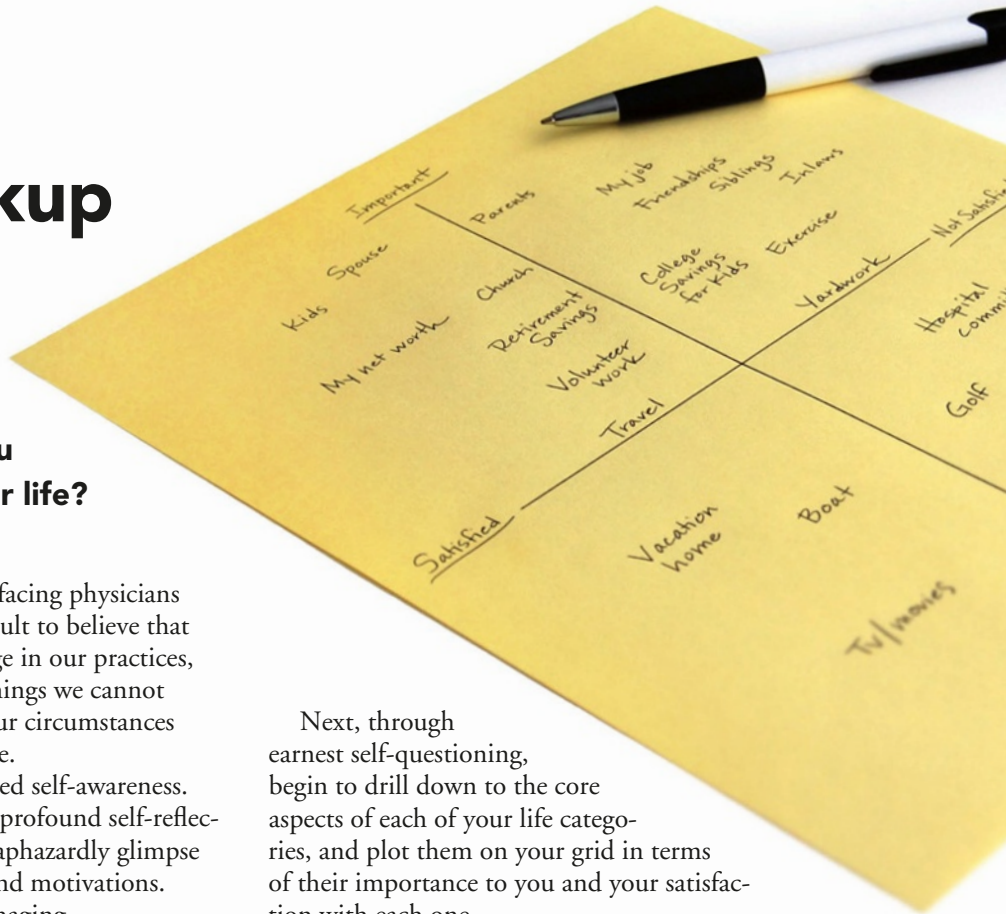
Annals of Family Medicine™
www.AnnFamMed.org

Indexed in the MEDLINE, MEDLARS, Science Citation Index Expanded, Current Contents/Clinical Medicine and PsycINFO databases. All published content deposited in PubMed Central.

INDEX OF ADVERTISERS

A Life Checkup

Don Kalman, MD



When was the last time you took an honest look at your life?

With the myriad challenges facing physicians today, it's sometimes difficult to believe that we can effect positive change in our practices, let alone in our lives. Clearly, some things we cannot control, but often we can influence our circumstances and relationships more than we realize.

One powerful first step is heightened self-awareness. Although we all have the capacity for profound self-reflection, most of us only fleetingly and haphazardly glimpse into the depths of our lives, choices and motivations. This lack of self-awareness can be damaging.

As family physicians, we recommend regular checkups for our patients. But when is the last time you took your life in for a checkup? I'm not talking about going to see a therapist or a life coach. When did you last take time out of your busy existence to engage in a deliberate, systematic and honest analysis of the way you are living your life?

A simple exercise

It may only take a few minutes to bring into focus the aspects of your life that most deserve your attention. Try this exercise: Take out a piece of paper, fold it into quarters and open it up. At the left end of the horizontal fold write "Satisfied," and at the right end write "Not Satisfied." At the top of the vertical fold write "Important," and at the bottom write "Not Important."

Now, think about all of the broad categories that make up your life – family, health, career, social life, leisure time, finances, community engagement, spirituality, etc. For each of us, these categories will be different.

Next, through earnest self-questioning, begin to drill down to the core aspects of each of your life categories, and plot them on your grid in terms of their importance to you and your satisfaction with each one.

To illustrate, let's use the example of family, which might have the following core aspects:

Significant other or spouse. How is your relationship in terms of communication and intimacy? Do you regularly spend time together engaged in activities you both enjoy? Do you too often take each other for granted?

Children. How do you relate to your children? Do you know what is going on in their lives? Do you eat meals together regularly if your kids still live at home?

Parents. Do you have aging parents in need of assistance? Do they live nearby or far away? Are you helping them? Are they afraid to ask for help?

Siblings, step-siblings or in-laws. Are you in touch with them regularly? If not, why not?

There are no right or wrong answers, just authentic ones. You will likely identify aspects of your life for which you are grateful. You may also find that you are dissatisfied with important parts of your life or spending too much time on things that are not important to you. Write down specific changes you can make, and then repeat the exercise in a few months.

By thinking about each aspect of your life in a diligent and systematic fashion, and exploring and wrestling with the major issues on a regular basis, you will move toward having a more meaningful and healthy life. FPM

Send comments to **fpmedit@aafp.org.**

About the Author

Dr. Kalman is a family physician at the University of California-Davis. Author disclosure: no relevant financial affiliations disclosed.

START AND STAY WITH

Colcrys®

(colchicine, USP) tablets

COLCRYS® (colchicine, USP) tablets for oral use

Brief Summary of full Prescribing Information

The following is a brief summary only. Please see full Prescribing Information for complete product information.

INDICATIONS AND USAGE

COLCRYS® (colchicine, USP) tablets are indicated for prophylaxis and the treatment of gout flares.

Prophylaxis of Gout Flares: COLCRYS is indicated for prophylaxis of gout flares.

Treatment of Gout Flares: COLCRYS is indicated for treatment of acute gout flares when taken at the first sign of a flare.

Familial Mediterranean fever (FMF): COLCRYS is indicated in adults and children 4 years or older for treatment of familial Mediterranean fever (FMF).

CONTRAINDICATIONS

Patients with renal or hepatic impairment should not be given COLCRYS in conjunction with P-gp or strong CYP3A4 inhibitors (this includes all protease inhibitors, except Fosamprenavir). In these patients, life-threatening and fatal colchicine toxicity has been reported with colchicine taken in therapeutic doses.

WARNINGS AND PRECAUTIONS

Fatal Overdose: Fatal overdoses, both accidental and intentional, have been reported in adults and children who have ingested colchicine. COLCRYS should be kept out of the reach of children.

Blood Dyscrasias: Myelosuppression, leukopenia, granulocytopenia, thrombocytopenia, pancytopenia, and aplastic anemia have been reported with colchicine used in therapeutic doses.

Drug Interactions: Colchicine is a P-gp and CYP3A4 substrate. Life-threatening and fatal drug interactions have been reported in patients treated with colchicine given with P-gp and strong CYP3A4 inhibitors.

If treatment with a P-gp or strong CYP3A4 inhibitor is required in patients with normal renal and hepatic function, the patient's dose of colchicine may need to be reduced or interrupted [*see DRUG INTERACTIONS*]. Use of COLCRYS in conjunction with P-gp or strong CYP3A4 inhibitors (this includes all protease inhibitors, except Fosamprenavir) is contraindicated in patients with renal or hepatic impairment [*see CONTRAINDICATIONS*].

Monitor for toxicity and if present consider temporary interruption or discontinuation of COLCRYS.

Neuromuscular Toxicity: Colchicine-induced neuromuscular toxicity and rhabdomyolysis have been reported with chronic treatment in therapeutic doses. Patients with renal dysfunction and elderly patients, even those with normal renal and hepatic function, are at increased risk. Concomitant use of atorvastatin, simvastatin, pravastatin, fluvastatin, gemfibrozil, fenofibrate, fenofibric acid, or benzafibrate (themselves associated with myotoxicity) or cyclosporine with COLCRYS may potentiate the development of myopathy [*see DRUG INTERACTIONS*]. Once colchicine is stopped, the symptoms generally resolve within 1 week to several months.

ADVERSE REACTIONS

Prophylaxis of Gout Flares: The most commonly reported adverse reaction in clinical trials of colchicine for the prophylaxis of gout was diarrhea.

Treatment of Gout Flares: The most common adverse reactions reported in the clinical trial with COLCRYS for treatment of gout flares were diarrhea (23%) and pharyngolaryngeal pain (3%).

FMF: Gastrointestinal tract adverse effects are the most frequent side effects in patients initiating COLCRYS, usually presenting within 24 hours, and occurring in up to 20% of patients given therapeutic doses. Typical symptoms include cramping, nausea, diarrhea, abdominal pain, and vomiting. These events should be viewed as dose-limiting if severe as they can herald the onset of more significant toxicity.

DRUG INTERACTIONS

COLCRYS is a substrate of the efflux transporter P-glycoprotein (P-gp). Of the cytochrome P450 enzymes tested, CYP3A4 was mainly involved in the metabolism of colchicine. If COLCRYS is administered with drugs that inhibit P-gp, most of which also inhibit CYP3A4, increased concentrations of colchicine are likely. Fatal drug interactions have been reported. Physicians should ensure that patients are suitable candidates for treatment with COLCRYS and remain alert for signs and symptoms of toxicities related to increased colchicine exposure as a result of a drug interaction. Signs and symptoms of COLCRYS toxicity should be evaluated promptly and, if toxicity is suspected, COLCRYS should be discontinued immediately. See full Prescribing Information for a complete list of reported potential interactions.

USE IN SPECIFIC POPULATIONS

- In the presence of mild to moderate renal or hepatic impairment, adjustment of dosing is not required for treatment of gout flare, prophylaxis of gout flare, and FMF but patients should be monitored closely.
- In patients with severe renal impairment for prophylaxis of gout flares the starting dose should be 0.3 mg/day, for gout flares no dose adjustment is required but a treatment course should be repeated no more than once every 2 weeks. In FMF patients, start with 0.3 mg/day and any increase in dose should be done with close monitoring.
- In patients with severe hepatic impairment, a dose reduction may be needed in prophylaxis of gout flares and FMF patients; while a dose reduction may not be needed in gout flares, a treatment course should be repeated no more than once every 2 weeks.
- For patients undergoing dialysis, the total recommended dose for prophylaxis of gout flares should be 0.3 mg given twice a week with close monitoring. For treatment of gout flares, the total recommended dose should be reduced to 0.6 mg (1 tablet) x 1 dose and the treatment course should not be repeated more than once every two weeks. For FMF patients the starting dose should be 0.3 mg per day and dosing can be increased with close monitoring.
- Pregnancy: Use only if the potential benefit justifies the potential risk to the fetus.
- Nursing Mothers: Caution should be exercised when administered to a nursing woman.
- Geriatric Use: The recommended dose of colchicine should be based on renal function.

Manufactured for:
AR SCIENTIFIC, INC. Philadelphia, PA 19124 USA
by:
MUTUAL PHARMACEUTICAL COMPANY, INC.
Philadelphia, PA 19124 USA

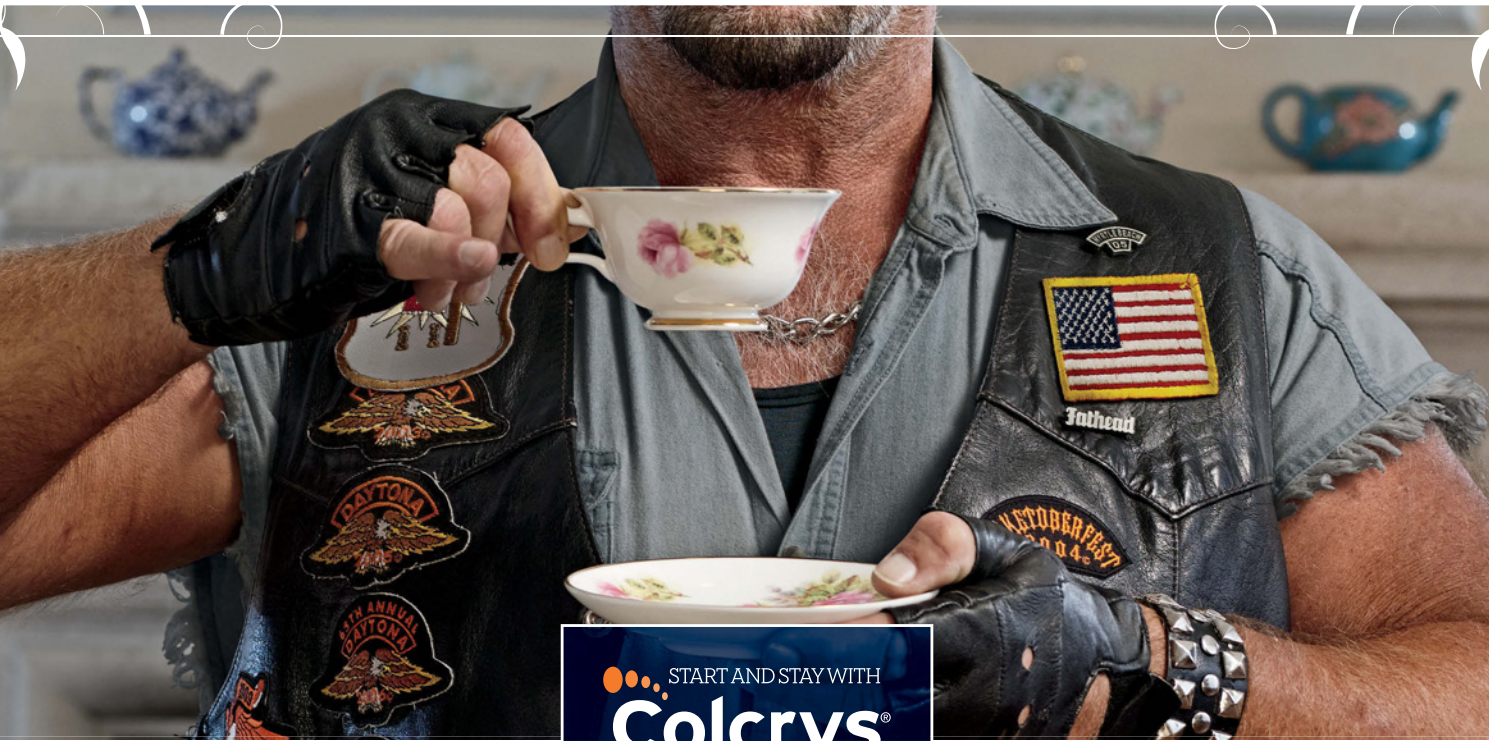
Rev 04, May 2010

Distributed by AR Scientific, Inc.
A URL Pharma company.
Philadelphia, PA
www.urlpharma.com

COL-550 June 2011

URL PHARMA
Smarter science. Safer medicines.

References: 1. Borstad GC, Bryant LR, Abel MP, Scroggie DA, Harris MD, Alloway JA. Colchicine for prophylaxis of acute flares when initiating allopurinol for chronic gouty arthritis. *J Rheumatol.* 2004;31(12):2429-2432. **2.** Becker MA, Schumacher HR Jr, Wortmann RL, et al. Febuxostat, a novel nonpurine selective inhibitor of xanthine oxidase: a twenty-eight-day, multicenter, phase II, randomized, double-blind, placebo-controlled, dose-response clinical trial examining safety and efficacy in patients with gout. *Arthritis Rheum.* 2005;52(3):916-923. **3.** Wortmann RL, MacDonald PA, Hunt B, Jackson RL. Effect of prophylaxis on gout flares after the initiation of urate-lowering therapy: analysis of data from three phase III trials. *Clin Ther.* 2010;32(14):2386-2397. **4.** Terkeltaub RA, Furst DE, Bennett K, Kook KA, Crockett RS, Davis MW. High versus low dosing of oral colchicine for early acute gout flare: twenty-four-hour outcome of the first multicenter, randomized, double-blind, placebo-controlled, parallel-group, dose-comparison colchicine study. *Arthritis Rheum.* 2010;62(4):1060-1068. **5.** COLCRYS [package insert]. Philadelphia, PA: AR Scientific, Inc. A URL Pharma company; 2010.



START AND STAY WITH

Colcrys®

(colchicine, USP) tablets

TOUGH, BUT GENTLE

COLCRYS effectively prevents gout flares when combined with uric acid–lowering therapy[1-3]

Low-dose colchicine, as found in COLCRYS, is well tolerated[1-5]

Save patients money with a $15* co-pay coupon at www.COLCRYS.com

Important Safety Information

COLCRYS (colchicine, USP) tablets are indicated for prophylaxis and the treatment of gout flares.

COLCRYS is contraindicated in patients with renal or hepatic impairment who are concurrently prescribed P-gp inhibitors or strong inhibitors of CYP3A4 as life-threatening or fatal toxicity has been reported. Dose adjustments of COLCRYS may be required when co-administered with P-gp or CYP3A4 inhibitors. The most common adverse events in clinical trials for the prophylaxis and treatment of gout were diarrhea and pharyngolaryngeal pain. Rarely, myelosuppression, thrombocytopenia, and leukopenia have been reported in patients taking colchicine. Rhabdomyolysis has been occasionally observed, especially when colchicine is prescribed in combination with other drugs known to cause this effect. Monitoring is recommended for patients with a history of blood dyscrasias or rhabdomyolysis.

You are encouraged to report negative side effects of prescription drugs to the FDA. Visit www.fda.gov/medwatch or call 1.800.FDA.1088.

You may also report negative side effects to the manufacturer of COLCRYS by calling 1.888.351.3786.

Please see brief summary of full Prescribing Information on adjacent page.

*Maximum savings of $75 per prescription.

URL Pharma

Distributed by AR Scientific, Inc. A URL Pharma company. Philadelphia, PA
www.urlpharma.com

©2011 URL Pharma, Inc. All rights reserved. COL-546 May 2011 Printed in USA.

www.COLCRYS.com | 1.888.351.3786