Appendix 1: Levels of Service Tip Sheet for Concise Evaluation and Management for Physicians in Training to Improved Billing at an Outpatient Academic Rheumatology Clinic.

Evaluation and Management levels of service are coded based on documentation of 1) the extent of history, 2) the extent of examination and 3) the complexity of medical decision making. All three are required for new patient clinic visits and consultations. Only two of these three key components are required for established patient clinic visits. It is essential to recognize that the codes are determined by the lowest level documented key component; they are not based on an average of the components. This means that small documentation errors are magnified greatly and can have a major impact.

Please also note that the goal of this project is to improve our billing for the work that you already perform. Do not perform and document additional history, examination or medical decision making with the sole purpose of increasing level of service of codes.

**Initial patient visits:**
The history should document the information gathered about the chief complaint, HPI, and ROS in addition to the past medical, family and social histories. It is not acceptable to write negative or noncontributory unless it is specified what they are negative for.

The HPI should be thorough and document at least 4 elements (location, severity, timing, modifying factors, quality, duration, context, and associated signs and symptoms).

It is necessary to document both positive and negative findings for the ten-point ROS. It is not appropriate to write, “complete ROS negative,” or to list the positive systems followed by “all other systems negative.”

When a complete physical examination has been conducted (which is usually the case for an initial patient visit), documentation should reflect findings regarding the eyes, ENT, CV, Pulm, GI, skin, neurologic, and psychiatric organ systems. Although “alert and oriented x 3” is sufficient for the psychiatry section, “Pleasant woman in NAD” is classified with the vitals under constitutional and does not count as an extra system. Please document your musculoskeletal exam as “detailed musculoskeletal exam” unless your exam is restricted to only several joints.

**Return patient visits:**
It is permissible to document, “The ROS is unchanged from date of last visit,” as long as a ROS is documented at that past visit and that the visit was within the past 12 months.

After reviewing the medical, family, and social histories it is fine to write “medical, family, and social histories were reviewed and are unchanged from date of last visit.”

Please document exam findings from appropriate organ systems. Please document your musculoskeletal exam as “detailed musculoskeletal exam” unless your exam is restricted to only several joints.