

PHA Documentation & Coding

Family Medicine Dept.

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&

Christina Guardiola-Holcomb

What is a PHA?

- Periodic Health Assessment
- Completed annually for all Active Component and Select Reserve Soldiers/Sailors/Airmen
 - An integral part of the Individual Medical Readiness System
- Provides **electronically recorded** annual assessment of every **ADSM's ability to deploy** anywhere in the world

The **HPI** needs to reflect:

- that the reason for the visit is for completion of a PHA.
- any condition/problems that will be addressed during the PHA visit.

The **Physical Examination** needs to reflect:

- any/all hands-on exams that are completed during the visit, addressing all issues documented in the HPI.

Assessment/Plan needs to reflect:

- documented medical decision(s) and plan for all issues addressed in the HPI and physical examination.

Disposition needs to reflect:

- accurate discharge status of the patient.

MEDPROS/MODS

PHAs: Although the history and/or physical exams for PHAs may be completed in MEDPROS, the information has to be cited in the AHLTA note. In this situation, a provider may document “Refer to MEDPROS for history and/or physical exam”; if the MEDPROS documentation supports the coding assigned for the AHLTA encounter, it will be considered acceptable for the CARA audit.

Under current guidance, if the MEDPROS documentation does not support the coding assigned for the AHLTA encounter, it will be marked incorrect for purposes of the CARA audit.

What E&M code do I use?

PHA

•99499 -

Non face-to-face record review, no exam, no counseling, reviewed by provider

•99420 -

Face-to-face record review, no exam, no counseling, reviewed by provider

•99401 -

Face-to-face encounter, no exam, counseling provided to an individual,
approximately 15 minutes

•99402

Face-to-face encounter, no exam, counseling provided to an individual,
approximately 30 minutes

PHA + condition/problem

•Appropriate PHA E&M (above) + 99201-99215 (w/ modifier 25)

Face-to-face record review, hands-on exam for a condition/problem that was addressed and documented during the PHA visit .

Coding Guidance

- On the previous slide, we see the most common codes associated with PHAs.
- Most commonly found when records are audited is 99420, face to face record review, no exam, no counseling, reviewed by provider.
- There might be times when counseling is done at these encounters; in which case 99401 and 99402 can be accessed.
- It is important to adhere to the guidelines; time and the elements of the conversation must be documented in the encounter.
- These specific counseling codes are distinct from other E/M service as they are for risk factor reduction services.
- They are for person/s without a specific illness but might require counseling on lifestyle modification for risky behavior, preventive counseling based on family history and occupational exposure.

HEALTH RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

Patient: [redacted] Date: 30 Nov 2011 1540 PST
Treatment: [redacted] Clinic: M FM HERON TEAM
Patient Status: Outpatient

Reason for Appointment: PHA 34yo
Appointment Comments:
tri/sc/PHA 34yo

AutoCites Refreshed by EPPEL,DIETER H @ 30 Nov 2011 1545 PST

Allergies
No Allergies Found.

Screening Written by CAMPBELL,JULIE @ 30 Nov 2011 1541 PST
Reason For Appointment: PHA 34yo

Allergen information verified [redacted]
[redacted] known.

Vitals
Vitals Written by CAMPBELL,JULIE @ 30 Nov 2011 1534 PST
BP: 141/75, HR: 97, RR: 18, T: 98 °F, HT: 64 in, WT: 147 lbs, BMI: 25.23, BSA: 1.716 square meters, Tobacco Use: No, Alcohol Use: No,
Pain Scale: 0 P [redacted] Comments: pt. states no pain

Questionnaire AutoCites Refreshed by EPPEL,DIETER H @ 30 Nov 2011 1545 PST
Questionnaires

SO Note Written by CAMPBELL,JULIE @ 30 Nov 2011 1544 PST

Chief complaint

The Chief Complaint is: Pha

History of present ill

The Patient is a
THE CLINIC'S IN-PERSON CLASSES AND AVAILABLE ONLINE SELF-MANAGEMENT SUPPORT RESOURCES WERE REVIEWED WITH THE PATIENT AND HANDOUTS WERE PROVIDED.

Medication list reviewed with patient, reconciliation completed, and list given to patient.

Attending Physician: <name>. Discussed with attending who concurs with the plan.

PainSeverity 0 / 10.

Pt. states no pain.

Current medication

CHLORHEXIDINE-MTH 0.12% LIQ SODIUM FLUORIDE (PREVIDENT 500.

Past medical/surgical history

Reported History:

Medical: Reported medical history.
Surgical / procedural: Surgical / procedural history
c-section-2005/2010

Reported medications: No medication noncompliance.

Personal history

Social history reviewed married with children.

Family history

Family medical history
grandmother-breast cancer.

Practice Management

Name/SSN: [redacted]
Sex: F Sponsor/SSN: [redacted]
FMP/SSN: [redacted] Tel H: 4 [redacted] Rank: [redacted]
DOB: [redacted] Tel W: [redacted] Unit: [redacted]
PCat: [redacted] CS: [redacted] Outpt Rec. Rm: [redacted] S
MC Status: [redacted] Status: [redacted] PCM: [redacted]
Insurance: No Tel. PCM: [redacted]



HEALTH RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

30 Nov 2011 1519

Facility: Madigan AMC-Fort Lewis

Clinic: Madigan Family Medicine Heron Team

Provider: E [redacted]

Preventive medicine services Lipid Panel -
Fasting Blood Sugar -
Aspirin Prophylaxis -
HIV Screen -
Colonoscopy -

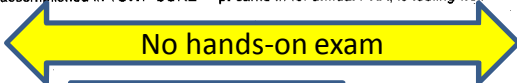
Tetanus (Td/Tdap) - 12 Aug 2011
Influenza -
Zoster -
Pneumococcal -
HPV -

Women:
Pap -
Mammogram -
Chlamydia Screen -
Osteoporosis Screen -
Folic Acid -

SO Note V [redacted] 15 PST

History of
The P

<<Note accomplished in TSWF CORE>> pt came in for annual PHA, is feeling well



A/P Written by EPP [redacted]

1. Visit for: military services physical(PERIODIC PREVENTION EXAMINATION): no medical or MH issues

Disposition Written by EPP [redacted] 30 Nov 2011 1557 PST

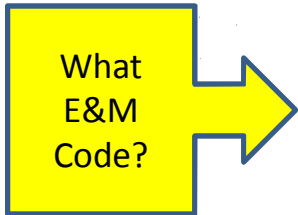
Released w/o Limitations

Follow up: as needed with PCM.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Signed By EPP [redacted]

Family Practice, Madigan AMC-Fort Lewis) @ 30 Nov 2011 1558



Name/SSN: [redacted]

FMP/SSN: [redacted]

DOB: [redacted]

PCat: [redacted]

MC Status: [redacted]

Insurance: No

Sex: [redacted]

Tel H: [redacted]

Tel W: [redacted]

CS: [redacted]

Status: [redacted]

Sponsor/SSN: [redacted]

Rank: [redacted]

Unit: [redacted]

Outpt Rec. Rm: MAMC STAFF FILES RECORDS

PCM: [redacted]

Tel. PCM: [redacted]



How to manually change
your E&M type...

QQQACCHCSII, ACTMALEMAMC M 20/806-06-7401 39yo M SMSgt DOB:18 Dec 1972

Reminders

Folder List

- New Results
- Tasking (3)
- Co-signs
- Sign Orders
- Consult Log
- Patient List
- CHCS-I
- Reports
- Tools
- Web Browser
- AHLTA Links
- QQQACCHCSII, ACTMALE
- Demographics
- Health History
- Problems
- Meds
- Allergy
- Wellness
- Immunizations
- Vital Signs Review
- Readiness
- Patient Questionnaire
- DoD/VA/Theater His
- Army Readiness
- BH Module
- Lab
- Radiology
- Clinical Notes
- Previous Encounters
- Flowsheets
- External Health Data Vie
- Current Encounter
- Screening
- Vital Signs Entry
- S/O
- Drawing

Appointments Previous Encounters Current Encounter Disposition

Disposition: Released w/o Limitations

Follow Up: With PCM When: PRN In Clinic:

Comments:

Encounter Context: Related to Injury/Accident?

Billing and Admin: Billing Chief Complaint: V70.5 2 - visit for: military services physical

Appt Class: Outpatient Observation Convalescent leave

Meets Outpt Visit Criteria (Workload)? No ?

Calculated Selection Additional E&M Coding

E&M Category: Preventive Medicine/Risk Factor Counseling

Selection E&M Code: 99420 (Administer/Interpret Health Risk Assessment)

E&M Codes:

E&M	Evaluation & Management
99401	Individual Prev Med/Risk Factor Counseling, 15 mins
99402	Individual Prev Med/Risk Factor Counseling, 30 mins
99403	Individual Prev Med/Risk Factor Counseling, 45 mins
99404	Individual Prev Med/Risk Factor Counseling, 60 mins
99411	Group Prev Med/Risk Factor Counseling, 30 mins
99412	Group Prev Med/Risk Factor Counseling, 60 mins
99420	Administer/Interpret Health Risk Assessment
99429	Unlisted Preventive Medicine Service

E&M Description: Administration & interpretation of health risk assessment instrument (health hazard appraisal)

Comments: Counseling done

-To manually change E&M code to the correct code
In the disposition section:
• click on the “selection” tab (#1)
• click on the E&M dropdown box (#2)
• then choose the correct E&M code that you need (#3)
-If a second E&M is needed, you can then go directly to the “sign” box in the top right

HEALTH RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

Patient: F [redacted] Date: 25 Apr 2012 1300 PDT Appt Type: EST
Treatment: [redacted] Clinic: M FM GOLDFINCH TEAM Provider: MUENCH,PETER D.
Patient St: [redacted]

Reason for Appointment: pha
Appointment Comments:
bem/muench

AutoCites Refreshed by MUENCH,PETER D @ 25 Apr 2012 1321 PDT

Allergies
• No Known Allergies

Vitals
No Vitals Found.

Screening Written by ZA [redacted]
Reason For Appointment:

Allergen information verified by ZAMIRA, TERI M @ 25 Apr 2012 1320 PDT

Vitals
Vitals written by ZA [redacted] @ 25 Apr 2012 1321 PDT
Uncorr OD: 20/20, Uncorr OS: 20/20, Uncorr OU: 20/15
Vitals written by ZAMIRA, TERI M @ 25 Apr 2012 1320 PDT
BP: 122/68 Left Arm, Adult Cuff, HR: 56, RR: 16, T: 97.8 °F, HT: 72 in, WT: 204.3 lbs Upright Scale, Actual, With Shoes, BMI: 27.71, BSA: 2.15 square meters

Questionnaire AutoCites Refreshed by MUENCH,PETER D @ 25 Apr 2012 1321 PDT
Questionnaires

SO Note Written by MUENCH,PETER D. @ 25 Apr 2012 1511 PDT

Chief complaint
The Chief Complaint is: PHA.
History of present illness

Cc and HPI correspond

The Patient is a 36 year old male.
<<Note accomplished in TSWF CORE>>
36-year-old active duty male, recent return to active duty after finishing nursing school, has obtained his RN. First visit here today.
1) needs his PHA completed. He has completed his portion online.
2) chronic right shoulder pain, present for several years, worse with weight lifting in the gym, worse with overhead activities, no trauma, no radicular symptoms, no weakness or numbness. No previous evaluation, no treatment thus far.
3) patient with history of moderately severe seasonal allergic rhinitis, while he was in nursing school he was seen at an allergist office and had been undergoing allergy injections, which he found quite helpful. He would like to continue these now that he is here at MAMC.
A PHA has been completed in past year. Date: 4/25/12.
Medication list reviewed with patient, reconciliation completed, and list given to patient.
Currently on active duty. Visit is not deployment-related.

Additional issues identified

Pain assessment: Right shoulder.
Pain Severity 2 / 10.
Additional Comments Pt health questionnaire all negative and no referral to Respect-mil needed.

Name/SSN: [redacted] Sex: M Sponsor/SSN: [redacted]
FMP/SSN: [redacted] Tel H: [redacted] Rank:
DOB: [redacted] Tel W: [redacted] Unit:
PCat: [redacted] CS: [redacted] Outpt Rec. Rm: MAMC STAFF FILES RECORDS
MC Status: [redacted] (DUTY) Status: PCM:
Insurance: No Tel. PCM:



-Here's another example of a PHA encounter.
-Notice that a visual acuity was done and results are documented.
-You can see how the cc is reflected in the HPI .
-Additional issues are identified and addressed

HEALTH RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

25 Apr 2012 1308
 Facility: Madigan AMC-Fort Lewis Clinic: M FM GOLDFINCH TEAM Provider: MUENCH,PETER D

PHQ-2 Depression Screen Negative.
Allergies .
 NKA.
Current medication .
 MVI daily
 Zyrtec 10mg prn
 Flonase prn
 Pataday eye drops prn.
Past medical/surgical history .
Reported History:
 Medical: Reported medical history
 Seasonal allergies.
 Surgical / procedural: Surgical / procedural history
 Tubes in ears
 Vasectomy
 Vasectomy reversal.
 Reported medications: No medication noncompliance.
Personal history .
 Social history reviewed Married. 2 children.
 Behavioral history: No tobacco use in the last 10 years.
 Alcohol: Alcohol use Screening Date:
 History ANNUAL SCREENING DATE:

 What is your preferred method of learning? Verbal Written Visual Other (Specify):
 Do you have a learning disability, language barrier, hearing/vision deficit? Yes No Specify:
 Advanced directives completed? Yes No
 Do you have any cultural or religious beliefs that may affect your care? Yes No
 Are you enrolled in EFMP? Yes No
 Do you use a Personal Health Record (PHR)? Yes No Specify:
 Contact info:
Family history .
 Family medical history
 Dad's side - HBP, heart disease.
Review of systems .
 Systemic symptoms: No fever and no chills.
 Gastrointestinal symptoms: No nausea, no vomiting, and no diarrhea.
Physical findings .
Vital signs:
 • Temperature: Reviewed. • RR: Reviewed. • PR: Reviewed. • Blood pressure: Reviewed.
General appearance:
 * Oriented to time, place, and person. * Well developed. * Well nourished. * In no acute distress.
Neurological:
 Gait And Stance: * Normal.
Psychiatric Exam:
 Mood: * Euthymic.
 Affect: * Normal.
Skin:
 • Skin: Visualized skin normal. * Showed no ecchymosis. * Temperature was normal. * No skin lesions.

A/P Written by MUENCH,PETER D @ 25 Apr 2012 1515 PDT
 1. visit for: military services physical(PERIODIC PREVENTION EXAMINATION): PHA completed.
 2. joint pain, localized in the right shoulder: Obtaining plain films now, referral made to sports medicine clinic for evaluation and treatment.
 Radiology(ies): -SHOULDER, RT (IMPINGEMENT) (Routine) Impression: 36yo AD male with chronic R shoulder pain with lifting. No
 Consult(s): -Referred To: M SPORT MEDICINE (Routine) Specialty: Clinic: M FP GOLD TEAM CLINIC Primary
 Diagnosis: joint pain, localized in the right shoulder
 3. ALLERGIC RHINITIS: Consult placed to MAMC allergy to continue allergy injections.
 Consult(s): -Referred To: M ALLERGY/IMMUNOLOGY (Routine) Specialty: Clinic: ALLERGY CLINIC Primary
 Diagnosis: Allergic rhinitis

Disposition Written by MUENCH,PETER D @ 25 Apr 2012 1516 PDT

Name/SSN:	Sex: M	Sponsor/SSN:
FMP/SSN:	Tel H:	Rank:
DOB:	Tel W:	Unit:
PCat:	CS:	Outpt Rec. Rm: MAMC STAFF FILES RECORDS
MC Statu:	JTY) Status:	PCM:
Insurance:		Tel. PCM:

-A hands-on physical exam is done and documented.
 -Correct dx coding for this encounter include those indicated above...the code for the PHA, R shoulder pain and allergic rhinitis as they were identified and addressed in the A/P.
 -The only thing missing from this is the CPT code for the visual acuity (99173).
 -That code would be associated with the PHA dx code as it is part of the physical.

Dx codes:
 V70.5 2 + R
 shoulder pain
 and allergic
 rhinitis.

Visual acuity CPT code
 could have been added
 and linked to the
 physical dx here

HEALTH RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

25 Apr 2012 1308

Facility: Madigan AMC-Fort Lewis

Clinic: M FM GOLDFINCH TEAM

Provider: MUENCH,PETER D

Released w/o Limitations

Follow up: as needed

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Administrative Options: Consultation requested

Signed By MUENCH, PETER D (Staff Physician, Family Medicine & Sports Medicine, Madigan Army Medical Center) @ 25 Apr 2012 1516

CHANGE HISTORY

The following SO Note Was Overwritten by MUENCH,PETER D @ 25 Apr 2012 1419 PDT:

SO Note Written by ZAMIRA,TERI M @ 25 Apr 2012 1321 PDT

Chief complaint

The Chief Complaint is: PHA

History of present illness

The Patient is a 35 year old male

A PHA has been completed in past year. Date: 4/25/12.

Medication list reviewed with patient, reconciliation completed, and list given to patient.

Currently on active duty. Visit is not deployment-related.

Pain Severity 2 / 10.

Pain assessment: Right shoulder.

PHQ-2 Depression Screen Negative.

Additional Comments: Pt health questionnaire all negative and no referral to Respect-mil needed.

Allergies

NKA

Current medication

MVI daily

Zynec 10mg prn

Floxase prn

Petaday eye drops prn

Past medical/surgical history

Reported History:

Medical: Reported medical history

Seasonal allergies

Surgical / procedural: Surgical / procedural history

Tubes in ears

Vasectomy

Vasectomy reversal

Reported medications: No medication noncompliance.

Personal history

Social history reviewed Married. 2 children.

Behavioral history: No tobacco use in the last 10 years.

Alcohol: Alcohol use Screening Date

History ANNUAL SCREENING DATE:

What is your preferred method of learning? Verbal Written Visual Other (Specify):

Do you have a learning disability, language barrier, hearing/vision deficit? Yes No Specify:

Advanced directives completed? Yes No

Do you have any cultural or religious beliefs that may affect your care? Yes No

Are you enrolled in EFMP? Yes No

Do you use a Personal Health Record (PHR)? Yes No Specify:

Contact info:

Family history

Family medical history

Dad's side - HBP, heart disease

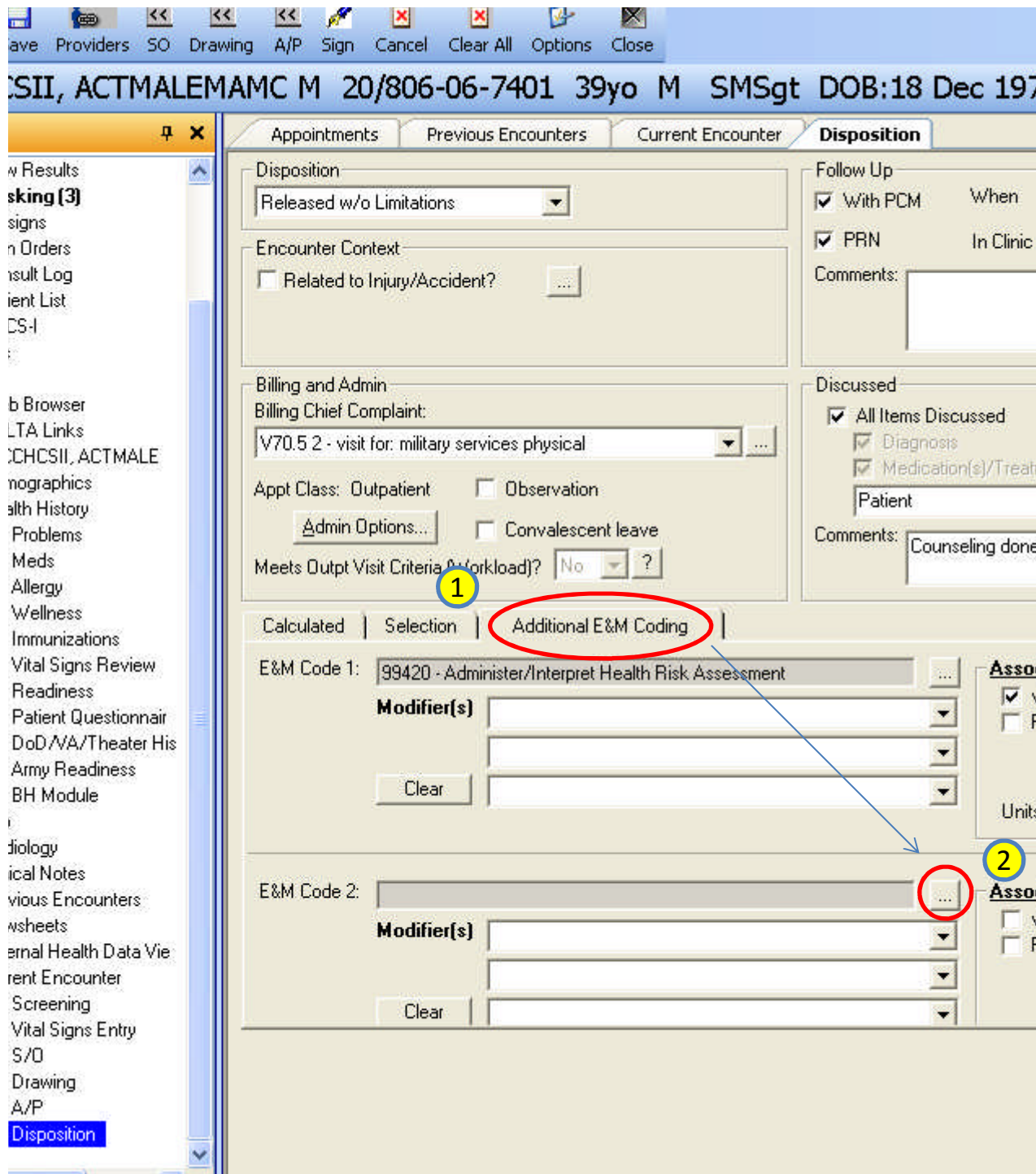
What E&M Code?

99420 + 99213 w/ mod. 25

Name/SSN: [Redacted]
FMP/SSN: [Redacted]
DOB: [Redacted]
PCat: [Redacted]
MC Statu: [Redacted]
Insurance: No

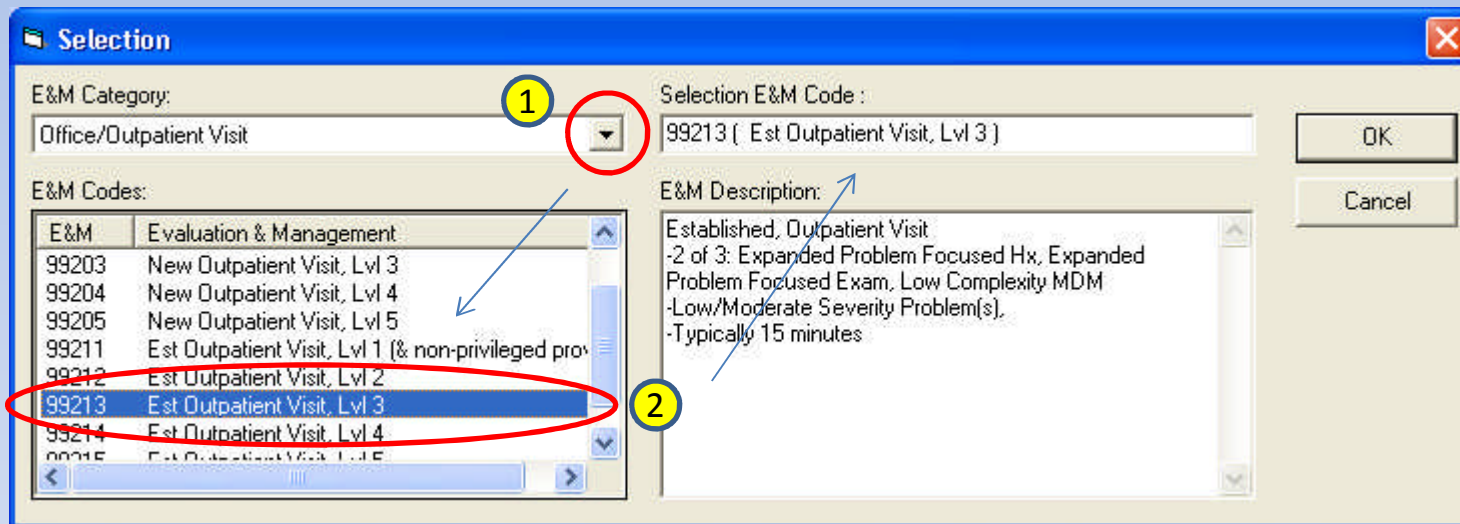
Sponsor/SSN: [Redacted]
Rank: [Redacted]
Unit: [Redacted]
Outpt Rec. Rm: MAMC STAFF FILES RECORDS
PCM: [Redacted]
Tel. PCM: [Redacted]

How to add 2nd E&M code
with Modifier 25...



Follow the instruction given and apply your first E&M code.
-After you've done that, the next is to add the 2nd E&M code with modifier 25.
-The modifier 25 is applied because it indicates a problem/illness/condition was addressed and documented in addition to the PHA.
-First, click on the "additional E&M coding" tab.
-You then click on the little box next to the "E&M Code 2" box.

- This is the box that pops up.
- You will again click on the E&M Category drop down box (#1)
- Pick the appropriate E&M based on the documentation of your additional workup (aside from the PHA information).
- You can see the E&M code that you pick/highlight now appears in the right side. This is the 2nd E&M code that will be embedded.
- Click OK.



Disposition
Released w/o Limitations

Encounter Context
 Related to Injury/Accident?

Billing and Admin
Billing Chief Complaint:
V70.5 2 - visit for: military services physical

Appt Class: Outpatient Observation
Admin Options... Convalescent leave

Meets Outpt Visit Criteria (Workload)? No ?

Follow Up
 With PCM When
 PRN In Clinic

Comments:

Discussed
 All Items Discussed
 Diagnosis
 Medication(s)/Treatment(s)

Patient
Comments: Counseling done

-Click on the dropdown box under the E&M code 2, where it says "modifier" in bold lettering

-Pick "25-Separate E&M, Same provider on same day"

-Notice that you should associate the diagnosis/diagnoses with the relevant E&M code.

-In this case, the 99420 is associated with the "visit for military services physical" which is V70.5 2

-The 2nd E&M code is associated with the shoulder pn and the allergic rhinitis (pretend that's what those associated dx's say on the 2nd E&M).

Calculated | Selection | Additional E&M Coding

E&M Code 1: 99420 - Administer/Interpret Health Risk Assessment

Modifier(s)

Associated
 visit for:
 Patient

Units Of Se

E&M Code 2: 99213 - Est Outpatient Visit, Lvl 3

Modifier(s)

25 - SEPARATE E&M, SAME PROVIDER ON SAME DA

21 - PROLONGED EVALUATION AND MANAGEMENT

22 - INCREASED PROCEDURAL SERVICES

24 - UNRELATED E&M SERV BY SAME PHYS DURING

24 - UNRELATED E&M SERV BY SAME PHYS DURING

24 - UNRELATED E&M SERV BY SAME PHYS DURING

24 - UNRELATED E&M SERV BY SAME PHYS DURING

25 - SEPARATE E&M, SAME PROVIDER ON SAME DA

Associated Diagnoses

visit for: military services physic...

Patient Counseling: Inquiry_Couns...

QQQACCHCSII, ACTMALEMAMC M 20/806-06-7401 39yo M SMSgt DOB:18 Dec 1972

- Reminders
- Folder List**
- New Results
 - Tasking (3)**
 - Co-signs
 - Sign Orders
 - Consult Log
 - Patient List
 - CHCS-I
 - Reports
 - Tools
 - Web Browser
 - AHLTA Links
 - QQQACCHCSII, ACTMALE
 - Demographics
 - Health History
 - Problems
 - Meds
 - Allergy
 - Wellness
 - Immunizations
 - Vital Signs Review
 - Readiness
 - Patient Questionair
 - DoD/VA/Theater His
 - Army Readiness
 - BH Module
 - Lab
 - Radiology
 - Clinical Notes
 - Previous Encounters
 - Flowsheets
 - External Health Data Vie
 - Current Encounter
 - Screening
 - Vital Signs Entry
 - S/O
 - Drawing

Appointments Previous Encounters Current Encounter **Disposition**

Disposition
Released w/o Limitations

Encounter Context
 Related to Injury/Accident?

Billing and Admin
Billing Chief Complaint:
V70.5 2 - visit for: military services physical

Appt Class: Outpatient Observation
 Convalescent leave

Meets Outpt Visit Criteria (Workload)? No ?

Follow Up
 With PCM When: For Tx:
 PRN In Clinic

Discussed
 All Items Discussed
 Diagnosis Potential Side Effects
 Medication(s)/Treatment(s) Alternatives
Patient indicated understanding

Comments: Counseling done

Calculated Selection Additional E&M Coding

E&M Code 1: 99420 - Administer/Interpret Health Risk Assessment
Modifier(s):
Clear

Associated Diagnoses
 visit for: military services physic...
 Patient Counseling: Inquiry_Couns...
Units Of Service: 1

E&M Code 2: 99213 - Est Outpatient Visit, Lvl 3
Modifier(s): 25 - SEPARATE E&M, SAME PROVIDER ON SAME DA
Clear

Associated Diagnoses
 visit for: military services physic...
 Patient Counseling: Inquiry_Couns...

HEALTH RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

Patient: QQQACCHCSII, ACTMALEMAMC M
Treatment Facility: MADIGAN AMC
Patient Status: Outpatient

Date: 09 May 2012 1144 PDT
Clinic: FPC MADIGAN

Appt Type: PROC\$
Provide [redacted]

Reason for Appointment:

AutoCites Refreshed by LEE,CARA D @ 09 May 2012 1147 PDT

Allergies
• OPIOID NARCOTICS - OTHER Class:
Unknown (ADDICTED)
• SULFA-DRUGS: Unknown

Screening Written by LEE,CARA D @ 09 May 2012 1148 PDT

Reason(s) For Visit (Chief Complaint): Visit for: military services physical (Follow-Up) ;

Vitals

Vitals Written by LEE,CARA D @ 09 May 2012 1151 PDT

Uncorr OD: 20/20, Uncorr OS: 20/20, Uncorr OU: 20/15

Vitals Written by LEE,CARA D @ 09 May 2012 1149 PDT

BP: 127/77, HR: 66, RR: 16, T: 97.4 F, HT: 67 in, WGT: 166 lbs, BMI: 25.37, BSA: 1.849 square meters, Tobacco Use: No, Alcohol Use: Yes.

Have you ever felt you should Cut down on your drinking? No.
Have people Annoyed you by criticizing or complaining about your drinking? No.
Have you ever felt bad or Guilty about your drinking? Yes.
Have you ever had a drink or drug in the morning (Eye opener) to steady your nerves or to get rid of a hangover? No.
Pain Scale: 0 Pain Free

Questionnaire AutoCites Refreshed by LEE,CARA D @ 09 May 2012 1147 PDT

Questionnaires

SO Note Written by LEE,CARA D @ 10 May 2012 0735 PDT

Chief complaint

The Chief Complaint is: PHA.

History of present illness

The Patient is a 39 year old male.
He reported: Encounter Background Information: Here today for PHA.
Military service in the Army and currently on active duty. Not currently deployed. Reservist, visit is GWOT-related, and deployed not currently deployed.

P1 U1 L1 H1 E1 S1

Active Duty Medical Readiness:

- 1. Member is able to perform their job without limitation
 - 2. Member is able to PT Test without limitation
 - 3. Member is able to Deploy
 - 4. Member is medically cleared for Flying / Controlling Duties if applicable.
- Date:

initial supplemental HPI [use for free text].

Past medical/surgical history

Reported History:

No recent change in medical history and no active problems.

Personal history

Personal history: Personal history pt typically drinks 4-6 beers every day.

Family history

Name/SSN: QQQACCHCSII, ACTMALEMAMC M

FMP/SSN: [redacted] Sex: M Sponsor/SSN: /806067401
DOB: [redacted] Tel H: Rank:
PCat: F11 USAF ACTIVE DUTY Tel W: Unit:
MC Status: CS: Outpt Rec. Rm:
Insurance: No Status: Fly,Jump,Mob PCM:
Tel. PCM:

CHRONOLOGICAL RECORD OF MEDICAL CARE
THIS INFORMATION IS PROTECTED BY THE PRIVACY ACT OF 1974 (PL-93-579). UNAUTHORIZED ACCESS
TO THIS INFORMATION IS A VIOLATION OF FEDERAL LAW. VIOLATORS WILL BE PROSECUTED.

STANDARD FORM 600 (REV. 5)
Prescribed by GSA and ICMR
FIRM (41 CFR) 201-45.505



-visual acuity was done
and documented
-Cc correlates with HPI

HEALTH RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

09 May 2012 1147

Facility: Madigan AMC-Fort Lewis Clinic: EPC MADIGAN

Provider: [Redacted]

Family history of cancer
Family history of heart disease

A/P Last updated by LEE, CARA D @ 10 May 2012 0741 PDT

1. visit for: military services physical (PERIODIC PREVENTION EXAMINATION): 39 year old AD healthy male. PHA signed off in MODS.

Procedure(s): -Screening Test Of Visual Acuity, Quantitative, Bilateral x 1

2. Patient Counseling: Inquiry & Counseling (OTHER SPECIFIED COUNSELING): Discussed/counseled etiology and disease process of CAD and testicular cancer with patient. Discussed and recommended to continue with current diet and exercise including the DASH diet. Noted weekly alcohol consumption and tiggers leading to. Discussed coping mechanisms to decrease consumption of alcohol. Spent total of 15 minutes counseling patient on these behavior and risk factors.

Disposition Last updated by LEE, CARA D @ 10 May 2012 0749 PDT

Released w/o Limitations

Follow up: as needed with PCM.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding. - Comments: Counseling done

Signed By [Redacted] (LPN, Madigan AMC-Fort Lewis) @ 10 May 2012 0801

Dx:
V70.5 2 +
V65.49 X

Counseling specifics and time MUST be documented

Brief, non-descriptive statements like; "Counseled on condition, diagnosis, or treatment alternatives" are not acceptable documentation in and of itself.

What E&M Code?

99401

-A positive family hx of diseases is noted.
-Everything that we're pointing out will be of significance in the coding...
-In the A/P you will notice the dx for the PHA and the counseling for risk factor reduction/behavior modification is related the positive family hx and his noted alcohol use.
-Patient status is correctly identified in the disposition.

Name/SSN: QQQACCHCSII, ACTMALEMAMC M

Sex: M Sponsor/SSN: /806067401
Tel H: Rank:
Tel W: Unit:
PCat: F11 USAF ACTIVE DUTY CS: Outpt Rec. Rm:
MC Status: Status: Fly,Jump,Mob PCM:
Insurance: No Tel. PCM:

Conclusion

- 99420 most common code
- 99401/02 may be accessed if counseling is documented
- Counseling must include time and elements of the conversation
- 99201-99215 E/M codes may be accessed for condition(s)/problem(s) were addressed during the PHA visit.
- Don't forget to add modifier 25 if you have a second E&M code.

