



# **Recommendation for Standardized Hospital Evaluation and Management Coding of Emergency Department and Clinic Services**

Produced by the  
Hospital Evaluation and Management Coding Panel  
of the  
American Hospital Association  
and  
American Health Information Management Association

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# **Hospital Evaluation and Management Coding Panel: Recommendation for Standardized Hospital Evaluation and Management Coding of Emergency Department and Clinic Services**

## **EXECUTIVE SUMMARY**

### **Background**

Since the inception of the Medicare hospital outpatient prospective payment system (HOPPS) in August 2000, hospitals have been coding clinic and emergency department visits using the same CPT<sup>®</sup> codes as physicians. But, these evaluation and management (E/M) codes describe professional services, not the services provided by the facility. In response, the Centers for Medicare & Medicaid Services (CMS) has allowed each facility to develop unique internal guidelines to report clinic and emergency department services provided by hospitals by mapping them to the levels of effort represented by the existing CPT<sup>®</sup> codes. As a result, today, each hospital has its own E/M methodology, although hospitals within the same health system may have the same or similar methodologies.

In its November 1, 2002 final rule for HOPPS (67FR66792), CMS called for “an independent expert panel” to develop consistent code definitions and guidelines to be used by the Medicare and Medicaid program for facility-based evaluation and management services. CMS suggested that organizations such as the American Hospital Association (AHA) and the American Health Information Management Association (AHIMA) had the expertise to develop such codes.

### **The Panel**

Because the lack of a standardized methodology for E/M services was a great concern for our members, the AHA and AHIMA convened a panel of experts in the areas of coding, health information management, documentation, billing, nursing, finance, auditing and medicine. The panel represented a wide variety of hospitals – large and small, urban and rural, teaching and nonteaching, and investor-owned and not-for-profit. In addition, the panel benefited from representation from the American College of Emergency Physicians (ACEP), the Emergency Nurses Association and the American Organization of Nurse Executives.

The panel met for two two-day meetings in Washington, DC and participated in more than 30 hours of meetings via conference calls. Decisions were made through a general consensus process.

### **The Charge**

The panel was charged with developing a methodology for consistent and standardized reporting to Medicare and third party payers of hospital emergency department and clinic visit E/M services. In addition, in its August 2000 Notice of Proposed Rulemaking, CMS cited several requirements “against which facility E/M coding guidelines would be measured” (67FR52131).

Convened in January 2003, the panel’s goal was to deliver a recommendation to CMS in time for the FY2004 HOPPS rulemaking process. This ambitious timeframe would allow sufficient time for CMS’ consideration, publication in a proposed rule, approval and hospital implementation as soon as possible for compliance with the Health Insurance Portability and Accountability Act’s

(HIPAA) transaction standards compliance deadline of October 16. Our members have been concerned that a lack of standardization would leave them at risk for noncompliance with the HIPAA code set standards.

### **Basics of the E/M Coding Model**

The panel reviewed CMS' published criteria for facility E/M coding guidelines and the existing models for coding emergency department and clinic E/M services. In addition, the panel established three key principles to guide group decision-making in the development of a model. First, the development of an E/M code set should accurately capture *hospital* resources consumed and used during an emergency or a clinic visit; therefore, physician services are not considered in applying the hospital E/M coding level. Second, in determining the code level, discrete hospital services that are separately billable, such as lab tests, should not be used in determining the coding level. Third, any coding model or models developed by the panel should be capable of being utilized for all health care payers, not just Medicare.

After evaluating various models currently in use for coding E/M services, including the ACEP model, point systems, intervention-based systems and time-based systems, the panel opted for a hybrid system that is a hospital staff intervention-based system that incorporates the attributes of many point systems. The panel realized that time-based models could be considered burdensome and difficult to implement; however, some limited components from time-based models were incorporated in the panel's clinic model in order to adequately capture the complexity of patient education and counseling occurring in specialty clinics.

The panel proposes the creation of three coding models, one for emergency department services, one for clinic services, and one for critical care level. Both the emergency department and clinic services model follow a three-level system of interventions (low, mid and high) plus a critical care level. The panel reached this decision for the following reasons:

- Our evaluation of sample models revealed that the largest area of overlap and ambiguity in proper level assignment appeared to be because of the greater number of levels with small differences in level assignment. In other words, the same interventions could be classified in level 1 or level 2, or level 4 and level 5. Therefore, a five-level system appeared to provide a lack of consistency in level of intervention determination within the contiguous levels.
- There was considerable difficulty in distinguishing the typical interventions performed in an emergency department and hospital clinic into more than three levels, once separately billable procedures were removed from the mix of interventions utilizing facility resources.
- Medicare's current reimbursement system under the outpatient prospective payment system's ambulatory patient classifications (APCs) collapses the existing five levels of CPT codes into three APC payment levels and thus supports the panel's simpler concept.

Collapsing the coding of E/M services to three levels in our model, when tested, provided better consistency, ease of use, reliability and appropriate application of an E/M coding system.

The emergency department (ED) and clinic models delineate a number of typical interventions that are part of an ED or a clinic visit. Interventions are assigned to one of three levels. Many

other factors may affect the facility resources utilized during an ED or a clinic visit; therefore, a list of contributory factors that may affect the complexity of patient services was developed. These contributory factors, when present, allow for the E/M level to increase by one additional level – up to a maximum of “high”.

Contributory factors alone cannot move the E/M episode up to the “critical care” level. The panel strongly believed that critical care was in itself a separate service with some interventions inherently considered critical care because of the patient’s acuity. The assignment of critical care, just as the other E/M levels, is based on hospital facility resources utilized (excluding separately billable procedures). E/M level assignment in the ED, clinic and critical care models does not rely on interventions performed by a physician. Physician services are only important to the extent that a hospital staff person may have been required to assist the physician.

Critical care interventions are the same whether they occur in the emergency department or the outpatient clinic setting, and the panel realized that for the most part critical care would probably occur in the ED. Therefore, only one coding model is presented for critical care services.

The panel has strived for clarity by providing definitions and examples to assist in level selection while avoiding subjective terms. The model is intended to be useful for different types of professionals – from the nurse caring for the patient, to the coder or biller who relies on a well-documented record for coding a level, to the auditor who may be reviewing the record for payment. The model requires good, consistent documentation of the patient encounter. It was clear from the panel’s review of existing models, that only with consistent documentation could any model achieve a high level of accuracy.

Both the clinic and the ED models have been field-tested multiple times by the panel members at several different stages of development, including the most recent drafts. The panel welcomes additional comment and input from other stakeholders as additional refinement may be required as part of the rulemaking process.

### **The Panel’s Recommendation**

The panel has worked extremely hard to develop a recommendation for a model that is user-friendly, easy to understand, medical record documentation-based and founded on solid clinical knowledge. While we believe these proposed models accurately reflect variation for facility outpatient E/M services, continued refinement will be required as in all coding systems.

**The panel recommends that its proposed methodology be adopted and new HCPCS codes be assigned to uniquely identify E/M facility services in the hospital ED, clinic and critical care.**

**For expediency, temporary HCPCS level II codes should be created and then transitioned to CPT® 4 E/M codes.** It is the panel’s recommendation that these E/M models be submitted to the CPT® Editorial Panel for unique codes to represent facility-based reporting of facility resources in the ED and hospital-based clinic setting.

In order to reduce the administrative burden for hospitals, the panel strongly recommends that the standardized methodology should be used for reporting hospital E/M services to all third-party payers, not just the Medicare and Medicaid programs.

# **Hospital Evaluation and Management Coding Panel: Recommendation for Standardized Hospital Evaluation and Management Coding of Emergency Department and Clinic Services**

## **FINAL REPORT**

### **Background**

Since the implementation of the Medicare hospital outpatient prospective payment system (HOPPS) in August 2000, hospitals have been coding clinic and emergency department visits using the same CPT<sup>®</sup> evaluation and management (E/M) codes as physicians. These codes, while having the exact same numeric value as the codes reported by physicians, have entirely different meanings for hospital reporting. Physician reporting refers to CPT<sup>®</sup> descriptors related to history, examination and complexity of medical decision-making. Hospital reporting refers to facility resources consumed by hospital staff.

The Center for Medicare & Medicaid Services (CMS) required each hospital to develop its own internal set of guidelines to report services by mapping them to the levels of effort represented by the CPT<sup>®</sup> codes. The only Medicare requirements were that these services must be documented and medically necessary, and that the mapping should reasonably reflect the intensity of the hospital's resources. Hospitals have struggled to create their own individual methodology for reporting E/M services with CPT<sup>®</sup> codes, and as a result, today each hospital or health system has its own E/M coding methodology.

### **Problem**

The absence of a standardized reporting methodology for E/M service has led to many problems. CMS has poor data to calculate crucial ambulatory patient classification (APC) reimbursement, since there is no standard definition or standard application of these facility-based E/M codes. With hospitals using different methodologies, (time, interventions, patient complexity or severity, etc.), each hospital's reported E/M levels reflect a different aspect of hospital resource utilization. Hospitals are concerned about possible violation of the Health Insurance Portability and Accountability Act (HIPAA) requirements for using standard code sets if CPT<sup>®</sup> codes are assigned without using the accompanying standard CPT<sup>®</sup> description.

### **Public Comments and CMS Rulemaking to Date**

In the August 21, 2001 proposed rule for HOPPS (66FR44672), CMS asked for public comment regarding national guidelines for hospital coding of emergency department and clinic visits. These comments were compiled and presented to the agency's APC panel in January 2002. CMS also announced that it planned to propose national facility coding guidelines in the proposed rule for the 2003 HOPPS update.

The August 9, 2002 proposed HOPPS rule (67FR 52091) contained a summary of the comments received by CMS:

- There was unanimous agreement that national guidelines for facility coding of emergency and clinic visits were required (with the exception of the American Medical Association (AMA) and one other physician organization). Most commenters requested that these

guidelines be established as soon as possible, but no later than January 2003. Among the reasons cited were:

- Compliance with HIPAA requirements. There is concern that use of E/M codes with different reporting rules and meanings when used by facilities would violate HIPAA requirements for using the standard code sets;
  - More effective audit and compliance programs;
  - Minimize confusion on the part of coders;
  - Minimize inaccurate payments, and
  - Prevent gaming of the system.
- Additionally, the need for two sets of guidelines emerged – one for emergency department visits and one for clinic visits.
  - There was unanimous agreement that the current CPT<sup>®</sup> descriptors for E/M services were inappropriate for facility coding, and confusing and misleading to coders and reviewers. All commenters recommended that new HCPCS codes be created for emergency department and clinic visits with descriptors specific for hospital coding.

Currently, there is no specific set of coding guidelines in widespread use at the present time; however, four basic types of E/M coding guidelines have been proposed to CMS for adoption:

- Staff time – based on the time staff spent with the patient. Higher levels are reported based on increments of time beyond baseline care.
- Staff intervention – based on the number or type of staff interventions performed by nursing or ancillary staff. Higher levels are reported based on the number and/or complexity of staff interventions.
- Resource intensity point scoring – based on points assigned to each staff intervention based on time, intensity and staff type required. The service level is determined by the sum of the points for all services provided.
  - Severity acuity point scoring – based on ICD-9-CM diagnosis codes, complexity of medical decision-making, or severity or acuity of patient’s presenting complaint or medical problem.

The most commonly recommended intervention-based guideline was the model developed by the American College of Emergency Physicians (ACEP). The American Hospital Association (AHA), the American Health Information Management Association (AHIMA) and the APC Advisory Panel originally supported this model for emergency department coding.

However, CMS raised its concern that all of the proposed guidelines allowed counting of separately paid services as “interventions” or “staff time” in determining a service level. CMS believes that the level of emergency and clinic visits should be determined by resource consumption that is not otherwise separately payable. For example, x-rays are separately payable and therefore they should not be one of the variables considered in determining E/M level – neither for the fact that the x-ray was taken nor for the staff time involved in making arrangements for the test, transporting the patient, etc.

## **CMS Considers National Coding Guidelines**

In the November 1, 2002 final rule for HOPPS (67FR66717), many commented that CMS should continue the current E/M coding structure until national coding guidelines with standard definitions could be established. Commenters also recommended that CMS convene a panel of experts to develop standard code definitions and guidelines that are simple to understand and implement and allow for compliance with HIPAA requirements.

CMS agreed that standard code definitions and guidelines should be implemented as soon as possible. In addition, the agency agreed that an independent expert panel should be convened. The panel should recommend to CMS definitions and guidelines for clinic and emergency department E/M codes. The recommendations should be provided in time for CMS to include them in the proposed rule for FY 2004. CMS stated that organizations such as the AHA and AHIMA have the expertise and are well equipped to provide the necessary ongoing education to providers.

- CMS also provided the following guidance, should an expert panel be formed: Definitions and guidelines should be developed using an open process involving a variety of experts (for example, clinicians, coders and compliance officers) in the field.
- The process should include adequate time to educate clinicians and coders and for hospitals to make the necessary system changes to accommodate the codes and guidelines.
- The panel should carefully review the principles and requirements for codes and guidelines that were announced in the proposed rule, and the guidelines must adhere to those principles and requirements (for example, guidelines must be resource-based).
- Such a panel should address CMS' concerns about existing guidelines (for example, potential for upcoding), in its recommendations.
- The independent expert panel review ACEP guidelines carefully, acknowledging the principles and requirements for codes and guidelines as indicated in the proposed rule.

### **The E/M Expert Panel**

Following the final 2002 HOPPS rule, the AHA and AHIMA met with CMS to discuss establishing an expert panel to address the need for facility E/M codes and guidelines. Both associations recognized that such an effort would benefit the hospital community and provide consistency in coding of the E/M facility activities. Both associations also recognized that to meet CMS' timeframe for including such codes in its FY2004 final rule there would have to be a significant effort on the part of the panel.

The AHA and AHIMA set some ground rules for such a panel. Both agreed to convene a panel of experts in the areas of coding, health information management, documentation, billing, nursing, finance, auditing and medicine. The panel would also represent a wide variety of hospitals – large and small, urban and rural, teaching and non-teaching, and investor-owned and not-for-profit. In addition, both agreed that the panel would benefit from representation from the ACEP, Emergency Nurses Association and the American Organization of Nurse Executives.

CMS and the AMA (the CPT<sup>®</sup> coding standards developer) were invited to serve as observers in the panel's meetings to ensure coordination with the CPT<sup>®</sup> coding system, which reports physician and other professional services, and to ensure that CMS would have the benefit of hearing discussions and debate in the development of the panel's recommendations.



Finally, CMS agreed to closely review and consider the expert panel's recommendations. However, the agency clearly stated that it would not commit to accept these recommendations in part or in whole.

The panel met for two two-day meetings in Washington, DC and participated in more than 30 hours of meetings via conference calls. Decisions were made through a general consensus process.

### **Key Principles**

The E/M panel worked under a consensus model and adopted several key principles to address the development of coding models to represent services rendered in hospital emergency departments and clinics. These principles included the principles set forth by CMS in its August 2002 proposed rule (67FR52131):

- Coding guidelines for emergency and clinic visits should be based on emergency department or clinic facility resource use, not physician resource use;
- Coding guidelines should be clear, facilitate accurate payment, be usable for compliance purposes and audits, and meet HIPAA requirements;
- Coding guidelines should only require documentation that is clinically necessary for patient care. Preferably coding guidelines should be based on current hospital documentation requirements, and
- Coding guidelines should not facilitate upcoding or gaming.

In this same proposed rule, CMS also suggested that the distribution of codes should result in a normal curve, and the panel agreed to look at this concept. However, the panel acknowledged that it would not have the means to determine the exact "curve" that any recommendation would make.

In addition, the panel agreed that any code system it developed should:

- Exclude any services or resources that were "separately billable" by the hospital;
- Be usable by all health care payers;
- Be tested by panel members to determine that such a system could work. (The panel recognizes that while its membership represents a broad cross-section of those covered by HOPPS, it may not be a statistical representative sample of the hospital outpatient emergency department and clinic community.

### **The Current System**

As stated previously, facilities currently code emergency and clinic visits using the same CPT<sup>®</sup> E/M codes as physicians. There are five CPT<sup>®</sup> E/M codes for emergency department services and 10 codes for clinic services. The codes used for clinic services differentiate between new and established patients, whereas the emergency department codes have no differentiation. In CPT<sup>®</sup>, a "new" patient is defined as one who has not received any professional services from the physician (the physician reporting the CPT<sup>®</sup> E/M code) or another physician of the same specialty who belongs to the same group practice, within the past three years. CPT<sup>®</sup> defines an "established" patient as one who has received professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years.

Under the HOPPS, CMS defines a “new “ patient as one who does not already have a hospital medical record number and an “established” patient as one that does have a hospital medical record number. However, the distinction between a “new” and “established” patient has no impact on reimbursement under the HOPPS.

All of the CPT<sup>®</sup> E/M codes were developed and defined to reflect the activities of physicians. The code descriptors relate to history, examination and complexity of medical decision-making. These components of a professional service do not represent the elements of a facility service that can be used to differentiate levels of complexity and resource utilization. Therefore, the CPT<sup>®</sup> E/M codes do not describe well, nor were they intended to describe, the facility component of an emergency or a clinic visit or the range and mix of services provided by facilities.

Under the HOPPS, the five CPT<sup>®</sup> codes for emergency department services and the 10 codes for clinic services were collapsed into three APCs for facility payment purposes. CMS recognized that the existing CPT<sup>®</sup> definitions did not reflect facility resources and allowed each facility to develop internal guidelines to map to the levels represented by the existing CPT<sup>®</sup> codes. These three levels are referred to as “low-level,” “mid-level,” and “high-level” emergency and clinic visits.

- Low-level visits include CPT<sup>®</sup> codes for levels one and two services (codes 99201, 99202, 99211, 99212, 99281 and 99282).
- Mid-level visits include level three services (codes 99203, 99213 and 99283).
- High-level visits include levels four and five services (codes 99204, 99205, 99214, 99215, 99284 and 99285).

The distinction between new and established patients in the CPT<sup>®</sup> codes for clinic visits is not considered significant for facility services and is therefore disregarded in the reimbursement methodology. In other words, a “low-level” clinic visit is assigned to the same APC, regardless of whether the patient is new or established.

Physicians determine the proper CPT<sup>®</sup> E/M code for reporting their services by referring to CPT<sup>®</sup> code descriptors and CMS’ documentation guidelines. Since the code descriptors and documentation guidelines do not apply to facility services, CMS instructed facilities develop their own guidelines for reporting the CPT<sup>®</sup> E/M codes. As stated earlier, this process has resulted in:

- Lack of national standardization in the facility reporting of CPT<sup>®</sup> E/M codes;
- Uncertainty on the part of facilities as to whether their internal guidelines would be acceptable to CMS and auditors, and
- Concerns expressed by facilities that this methodology violates HIPAA regulations.

The use of definitions and reporting rules for CPT<sup>®</sup> E/M codes that are different from those established by the CPT<sup>®</sup> maintenance organization (the AMA) could represent non-compliance with the HIPAA standards for electronic transactions and code sets.

## **RECOMMENDATION**

Following numerous meetings and field-testing; the panel recommends the following E/M facility guidelines, which include creating three separate models—one each for emergency, clinic and critical care services.

### **Create Three Levels of E/M Facility Care**

The panel's proposed models follow a three-level system (low, mid and high) for ED and clinic services plus a critical care level. This proposal departs from the current five-level system for the following reasons:

- Evaluation of sample models revealed that the greatest area of overlap and ambiguity in proper level assignment appeared to be because of the higher number of levels with small differences in level assignment. In other words, the same interventions could be classified in level 1 or level 2, or level 4 and level 5. Therefore, a five-level system appeared to provide a lack of consistency in facility level of determination within the contiguous levels.
- There was considerable difficulty in distinguishing the typical interventions performed in an emergency department and hospital clinic into more than three levels, once separately billable procedures were removed from the mix of interventions utilizing facility resources.
- Medicare's current reimbursement system under the outpatient PPS's ambulatory patient classifications (APCs) collapses the existing five levels of CPT<sup>®</sup> codes into three APC payment levels and thus supports this simpler concept.

Collapsing the coding of E/M services to three levels in our model, when tested, provided better consistency, ease of use, reliability and appropriate application of a facility services E/M coding system.

### **Create an Intervention-based Emergency Department Model**

Development of an emergency department model began with an evaluation of the ACEP model, which is well developed and previously had been recommended for use in hospital E/M coding by the AHA and AHIMA. While the ACEP model has many positive components, its reliance on physician services and separately billable items was contrary to the panel's key principles. Other models were also evaluated for potential use and this process allowed panel members to become more familiar with the various methods for determining code levels.

The panel also spent a great deal of time isolating services where hospital staff provided care, rather than the physician, and where there was no other mechanism for billing for these services. This process led to the identification of many interventions and treatments that represent hospital staff E/M services. The panel developed a model consisting of three levels. Discussion and testing of this option was given much consideration.

While the emergency department E/M model is an intervention-based model, it also incorporates some attributes of a point system. The model allows the accumulation (three or more) of some interventions to increase the E/M level to the next level (low-level to mid-level or mid-level to high-level). The model also identifies certain contributory factors that, when present, increase

the E/M level. These factors increase the complexity, time and/or resources required to provide E/M services. The panel reviewed and tested the model multiple times. This process allowed for refinement and clarification of interventions and the development of the list of contributory factors.

### **Create an Intervention-based Clinic Model**

Developing a clinic model was more challenging than the emergency department model, due to the wide variety in types of clinics and insufficient documentation in many clinical records to determine the extent of patient-staff interaction and all of the services provided during a clinic visit. While the panel recognized the existence of significant differences in the services provided in diverse types of clinics, they felt it was not feasible to develop separate E/M models for different types of clinics. Also, many of the differences involve separately billable services and, therefore, can be accounted for outside of the E/M model.

The panel decided to develop a model consisting of three levels for two reasons. First, this approach would result in consistency and simplicity – it mirrors the number of levels in the emergency department model. Second, many of the difficulties in establishing more than three levels in the emergency model (such as inability to consistently distinguish contiguous levels) were also apparent in the clinic setting. Also, just as for the emergency model, the panel chose to develop a hybrid system that is primarily intervention-based but encompasses some attributes of a point system. No distinction was made for new and established patients in our clinic model, since it was felt to be irrelevant for facility reporting.

Although there was some discussion of “time” as a key indicator of facility resources in a clinic setting, the panel chose not to develop a clinic model based on time, primarily because time is frequently not documented in clinic records. The panel did not want to impose new administratively burdensome documentation requirements that would not have a positive impact on patient care. However, some limited components from time-based models were incorporated in the clinic model in order to adequately capture the complexity of patient education and counseling provided in specialty clinics.

Panel members reviewed a sample of clinic records and solicited input from their organizations’ clinic staff to identify common attributes of a clinic visit. These were used as the basis for identifying key interventions performed as part of the evaluation and management component of a clinic visit. Additionally, interventions included in the emergency department model that would also apply to the clinic setting were incorporated in the clinic model. Several sample clinic models were also reviewed to identify any additional interventions that should be included in our model. As in the emergency department model, separately billable services were not included in the interventions. Contributory factors were developed that are believed to impact the complexity of a clinic visit and, therefore, when present, can be used to move the visit to the next higher E/M level.

Accounting for unique characteristics of specialty clinics was particularly challenging, and the panel expects refinements will be made as the health care field gains familiarity and experience with using the model. For example, a great deal of discussion ensued on the best way to account for differences in the time and resources expended on various interventions and services.

### **Create an Intervention-based Critical Care Model**

Development of the critical care model consisted of identification of clinical interventions for critically ill or critically injured patients. The panel determined that these interventions (like the interventions in the emergency department and clinic models) should reflect services performed by hospital staff, rather than the physician. The nature of the patient's critical condition would determine the need for these interventions, and these interventions would not overlap with interventions in the emergency department or clinic model. In other words, no matter how many interventions from the emergency department or clinic model were performed, they could not add up to a critical care level. It was felt that the critical care was a model in of itself.

Since critical care services were thought to be the same regardless of the setting, the critical care model is the same for the emergency department and the clinic setting.

## **REMAINING ISSUES**

### **Wound Care**

The panel had extensive discussions regarding the best way to capture the differences in complexity of services provided in wound care clinics. The panel struggled to identify variables useful to determine E/M levels for wound care. Variables considered were wound size, wound depth, length of time spent with the patient, dressing size, etc. While the panel was unable to address all the concerns surrounding wound care, wound size has been selected as a determinant for E/M level assignment. Additional input is required to determine if wound size is the best variable; whether the threshold for wound size is appropriate; other appropriate variables, and whether multiple variables could be considered, given feasibility, consistency of application and ease of use.

### **Education**

Hospital staff will require education on the model for facility reporting of E/M services. The extent of training will depend on the type of model the emergency department or clinic is currently using. In some cases, our model may be simpler and easier to understand than the model they are currently using. In addition to understanding the interventions in each level, hospital staff will need to understand how the contributory factors affect level assignment. They also will need to understand what medical record documentation will be necessary to support the interventions, and any contributory factors used to determine the appropriate E/M level. For some interventions and contributory factors, medical record documentation may need to be improved. For example, face-to-face patient education of a specified length of time is included as an intervention in level three and under the contributory factors. Time spent providing patient education may not currently be documented in the patient's medical record.

### **Further Refinement**

The panel has worked extremely hard to develop a recommendation for a model that is user-friendly, easy to understand, medical record documentation-based and founded on solid clinical knowledge. While we believe these models accurately reflect variation for facility outpatient E/M services, continued refinement will be required as in all coding systems. The panel recommends that this model be proposed as part of the 2004 outpatient rulemaking process and

looks forward to working with CMS to incorporate any recommendations raised during the public comment period.

# **Emergency Department Model**

# Emergency Department E/M Model 6/16/03 Draft

## Definition of Emergency Department Visit

**A patient who presents to the emergency department for services, is registered and receives one or more of the clinical interventions listed below.**

## Level 1 (Low Level) Interventions

**At least one item below qualifies for low level.** Additional explanations, examples and clarifications appear in italics. Items below as performed by hospital staff, rather than physician. Three or more of the interventions identified by an asterisk qualify for mid-level (level 2). Each line item may only be used once towards this increase.

* Administration of oral, topical, rectal, PR, NG or SL medication(s)	
* Administration of single disposable enema	
* Application of preformed splint(s)/elastic bandage(s)/sling(s), or immobilizer(s) for non-fracture or nondislocation injuries	<i>Preformed are off-the shelf. If creating a splint from plaster or fiberglass or other material, would have separate code. Splints are not billed separately. Splints, casting, etc. for fractures are separately billable and paid under the fracture management.</i>
* Assisting physician with examination(s)	<i>Pelvic exam included here. Includes eye exam/slit lamp exam of eye. Nursing documentation must support assistance, unless there is a hospital protocol regarding assistance with exam.</i>
* Bedside diagnostic testing, unless tests are separately billed.	<i>Examples: Dip stick urine testing, capillary blood sugar (Accucheck, Dextrostick), hemocult, occult blood tests. Strep test is not included because it is separately billable.</i>
* Cleaning and dressing of a wound, single body area, not repaired (but includes butterflies)	<i>Examples: steri-strips and other adhesives, eye patch</i>
* First aid procedures	<i>Examples: control bleeding, ice, monitor vital signs, cool body, remove stinger from insect bite, cleanse and remove secretions</i>
* Flushing of Heplock	
Follow-up visit	<i>Definition: Patient instructed to return for wound check or suture removal or rabies injection series.</i>
* Foreign body(ies) removal of skin, subcutaneous or soft tissue without anesthesia or incision	
Initial clinical assessment	<i>Example: Vitals, chief complaint, and clinical assessment of symptom. All elements must be present.</i>
Measurement/Assessment of fetal heart tones	
Nursing visual acuity assessment (e.g. Snellan exam)	
* Specimen(s) collection other than venipuncture, e.g. mid-stream urine samples, cultures	<i>Example: nursing instruction of patient on proper specimen collection (e.g. mid-stream urine, sputum). Includes collection of specimen (not the performance of the lab test), e.g. throat culture collection.</i>



## Level 2 (Mid-Level) Interventions

**At least one item below qualifies for mid-level.** Additional explanations, examples and clarifications appear in italics. Items below as performed by hospital staff, rather than physician. Three or more of the interventions below identified by an asterisk qualify for high-level (level 3). ). Each line item may only be used once towards this increase.

<b>* Assistance with or performance of fecal disimpaction (manual disimpaction or multiple enemas)</b>	
<b>* Cardiac monitoring</b>	<i>Includes one or more of the following: physical assessment by the nurse after initiation of cardiac monitoring, and/or pulses, and/or heart sounds, and/or nursing interpretation of strips.</i>
<b>* Care of device(s) or catheter(s) (both indwelling and in &amp; out) (vascular and nonvascular) and/or ostomy device(s)--other than insertion or reinsertion-</b>	<i>Examples: irrigation, inspection, assessment, flushing, adjustment, positioning, changing of bags, checking. Examples of catheters/devices: foley, ileal conduit, gastrostomy, ileostomy, colostomy, nephrostomy, tracheostomy, PEG tube, central lines, arterial lines, PICC lines.</i>
<b>Frequent monitoring/assessment as evidenced by three sets of vital signs or assessments (including initial set), integral to current interventions and/or patient's condition.</b>	<i>Example: Additional vital signs, assessment of cardiovascular, pulmonary or neurological status, assessment of pain scale, pulse oxymetry or peak flow measurement.</i>
<b>* Insertion of nasogastric (NG) tube or oral gastric (OT) tube</b>	
<b>* Nasotracheal (NT) or orotracheal (OT) suctioning</b>	
<b>* Oxygen administration--initiation and/or adjustment from baseline oxygen regimen</b>	<i>Includes conversion to hospital-supplied oxygen with rate adjustments, as well as initiation of oxygen administration.</i>
<b>* Traction set up</b>	<i>Application of traction device for comfort (includes hair traction, Sager traction) prior to definitive treatment.</i>

## Contributory Factors for ED E/M Model From Low Level to Mid-Level OR From Mid-Level to High Level

**Contributory factors are services, or other factors that when present may increase the E/M assignment by one level. Only one factor is required. These factors apply only to the low level and the middle level. A high level E/M may not be increased to critical care by a contributory factor.** Additional explanations, examples and clarifications appear in italics.

<b>Airway insertion (nasal, oral)</b>	
<b>Altered mental status</b>	
<b>Arrangements and/or social service intervention (includes required reporting)</b>	<i>Examples: Arrangements and/or social intervention for child abuse, battery, elder abuse, etc.</i>
<b>Scheduling/coordination of ancillary services</b>	
<b>Arrival/transfer via paramedic/ambulance</b>	
<b>Assessments or care related to multiple catheters or devices</b>	<i>Examples of catheters/devices: foley, gastrostomy, ileostomy, colostomy, tracheostomy, PEG tube, central lines, arterial lines, PICC lines.</i>
<b>Isolation</b>	
<b>Multiple nursing interventions--three or more different types of interventions. Only interventions identified by an asterisk apply.</b>	<i>Example: Three bedside diagnostic tests would only be counted as one item because they are both included in one category. This example would NOT qualify as a contributory factor.</i>
<b>Patient acuity warrants simultaneous care by hospital staff (more than one-on-one)</b>	
<b>Patient discharge status other than home or discharge to facility other than originating facility (includes also admission to hospital inpatient or observation)</b>	
<b>Reporting to law enforcement or protective services (e.g., gunshots)</b>	
<b>Special needs requiring additional specialized facility resources (e.g. language/cognitive, communication impairment) - age appropriate</b>	<i>Example: Patient doesn't understand English and requires use of an interpreter. However, if patient doesn't understand English, but nurse speaks the same language and is able to translate, then no additional specialized resources were required and would not</i>

qualify as a contributory factor.

### Level 3 (High Level) Interventions

**At least one item below qualifies for high level.** Additional explanations, examples and clarifications appear in italics. Items below as performed by hospital staff, rather than physician

<b>Administration of multiple concurrent intravenous (IV) infusions (2 or more) through different lines or through one or more multiple lumen lines</b>	<i>(Separately billable only for one line per encounter)</i>
<b>Assessment, crisis intervention and supervision of imminent behavioral crisis threatening self or others</b>	
<b>Assistance with or performance sexual assault exam by hospital nursing staff</b>	
<b>Continuous irrigation of eye using therapeutic lens (e.g. Morgan lens)</b>	
<b>Core temperature interventions (e.g. heated or cooled IV fluids, heated or cooled gastric lavage, heated or cooled peritoneal lavage)</b>	
<b>Decontamination of hazardous material threatening life, limb or function by irrigation of organs of special sense, or administration of antidotes or showering.</b>	
<b>Monitoring and related attendance of moderate sedation</b>	<i>Example: Monitoring and related attendance of "conscious sedation"</i>
<b>Precipitous delivery of baby</b>	
<b>Continuous ongoing nursing assessments as evidenced by more than three sets (including initial set) of vital signs or assessments integral to current interventions and/or patient's condition.</b>	<i>Example: Additional vital signs, assessment of cardiovascular, pulmonary or neurological status, assessment of pain scale, pulse oxymetry or peak flow measurement.</i>

# **Hospital Clinic Model**

## Clinic E/M Model 6/16/03 Draft

### Definition of Clinic Visit

A patient who presents to the hospital clinic for services, is registered and receives one or more of the clinical interventions listed below.

### Level 1 (Low Level) Interventions

At least one item below qualifies for low level. Additional explanations, examples and clarifications appear in italics. Items below as performed by hospital staff, rather than physician.

<b>Bedside diagnostic testing, unless tests are separately billed.</b>	<i>Examples: Dip stick urine testing, capillary blood sugar (Accucheck, Dextrostick), hemocult, occult blood tests. Strep test is out, separately billable.</i>
<b>Blood pressure recheck</b>	
<b>Clinical staff assessment (excluding physician)</b>	<i>Example: Vitals, or chief complaint, or clinical assessment of symptom.</i>
<b>Flushing of Heplock</b>	
<b>Patient registration, room set up, patient use of room, room cleaning—not covered by a separately billable procedure.</b>	
<b>Routine simple discharge instructions</b>	
<b>Single specialized clinical measurement or assessment</b>	<i>Example: fetal heart tones, positional blood pressure readings, Snellan exam, and cardiac monitor rhythm strip performed by nurse.</i>
<b>Specimen collection(s), where nurse provides patient with instructions and patient self-collects, other than venipuncture, e.g. mid-stream urine samples.</b>	<i>Example: nursing instruction of patient on proper specimen collection (e.g. mid-stream urine, sputum). Includes collection of specimen (not the performance of the lab test).</i>
<b>Suture or staple removals</b>	
<b>Tuberculosis test check</b>	
<b>Wound care management (when not separately billable), not repaired – up to 25 sq. cm.</b>	<i>Includes cleansing, assessment, measurement, photographing, ankle brachial index, and/or dressing of wound. Includes steri-strips and other adhesives, eye patch, butterflies. Note: For multiple wounds, add the total size of all wounds.</i>

### Level 2 (Mid-Level) Interventions

At least one item below qualifies for mid-level. Additional explanations, examples and clarifications appear in italics. Items below as performed by hospital staff, rather than physician.

<b>Administration of oral, topical, rectal, PR, NG or SL medication(s)</b>	
<b>Administration of single disposable enema</b>	
<b>Application of preformed splint(s)/elastic bandages/sling(s), or immobilizer for non-fracture or nondislocation injuries, when not separately billable as a procedure.</b>	<i>Preformed are off-the shelf. If creating a splint from plaster or fiberglass or other material (custom-made splint), would have separate code. Splints are not billed separately. Splints, casting, etc. for fractures are separately billable and paid under the fracture management.</i>
<b>Assist physician with examination</b>	<i>Pelvic exam included here. Includes eye exam/slit lamp exam of eye. Nursing documentation must support assistance, unless there is a hospital protocol regarding assistance with exam.</i>
<b>Blood draw(s) through specialized vascular access device</b>	

<b>Care of device(s) or catheter(s) (both indwelling and in &amp; out) (vascular and nonvascular) and/or ostomy device(s)--other than insertion or reinsertion</b>	<i>Examples: irrigation, inspection, assessment, flushing, adjustment, positioning, changing of bags, checking. Examples of catheters/devices: foley, ileal conduit, gastrostomy, ileostomy, colostomy, nephrostomy, tracheostomy, PEG tube, central lines, arterial lines, PICC lines.</i>
<b>First aid procedures</b>	<i>Examples: control bleeding, ice, monitor vital signs, cool body, remove stinger from insect bite, cleanse and remove secretions</i>

<b>Foreign body(ies) removal of skin, subcutaneous or soft tissue without anesthesia or incision, when not a separately billable procedure.</b>	
<b>Frequent monitoring/assessment as evidenced by two sets of vital signs or assessments (including initial set), integral to current interventions and/or patient's condition.</b>	<i>Example: Additional vital signs, assessment of cardiovascular, pulmonary or neurological status, assessment of pain scale, pulse oxymetry or peak flow measurement.</i>
<b>Oxygen administration--initiation and/or adjustment from baseline oxygen regimen</b>	<i>Includes conversion to hospital supplied oxygen with rate adjustments, as well as initiation of oxygen administration.</i>
<b>Specimen collection(s) other than venipuncture, performed by nursing staff, e.g. cultures</b>	<i>Collection of specimen (not the performance of the lab test), e.g. throat culture collection.</i>
<b>Wound care management (when not separately billable), not repaired – 26-50 sq. cm.</b>	<i>Includes cleansing, assessment, measurement, photographing, ankle brachial index, and/or dressing of wound. Includes steri-strips and other adhesives, eye patch, butterflies. Note: For multiple wounds, add the total size of all wounds.</i>

### **Contributory Factors For Clinic E/M Model From Low Level to Mid-Level OR From Mid-Level to High Level**

**Contributory factors are services, or other factors that when present may increase the E/M level from mid-level to high level. Only one factor is required. These factors apply only to the low level and the middle level. A high level E/M may not be increased to critical care by a contributory factor. Additional explanations, examples and clarifications appear in italics.**

<b>Airway insertion (nasal, oral)</b>	
<b>Altered mental status</b>	
<b>Arrangements and/or social service intervention (includes required reporting)</b>	<i>Examples: Arrangements and/or social intervention for child abuse, battery, elder abuse, etc.</i>
<b>Scheduling/coordination of ancillary services</b>	
<b>Arrival/transfer via paramedic/ambulance</b>	
<b>Assessments or care related to multiple catheters or devices</b>	<i>Examples of catheters/devices: foley, gastrostomy, ileostomy, colostomy, tracheostomy, PEG tube, central lines, arterial lines, PICC lines.</i>
<b>Face to face patient education requiring 30-59 minutes.</b>	<i>Documentation will support the content of the education, time involved, and any factors that impacted on the time required. Examples include crutch training, diabetic teaching, counseling regarding diet, exercise, and other lifestyle changes.</i>
<b>Isolation</b>	
<b>Patient acuity warrants simultaneous care by hospital staff (more than one-on-one)</b>	
<b>Patient discharge status other than home or discharge to facility other than originating facility (includes also admission to hospital inpatient or observation)</b>	
<b>Reporting to law enforcement or protective services (e.g., gunshots)</b>	
<b>Special needs requiring additional specialized facility resources (e.g. language/cognitive, communication impairment) - age appropriate</b>	<i>Example: Patient doesn't understand English and requires use of an interpreter. However, if patient doesn't understand English, but nurse speaks the same language and is able to translate, then no additional specialized resources were required and would not qualify as a contributory factor.</i>

### Level 3 (High Level) Interventions

**At least one item below qualifies for high level.** Additional explanations, examples and clarifications appear in italics. Items below as performed by hospital staff, rather than physician

<b>Assessment, crisis intervention and supervision of imminent behavioral crisis threatening self or others</b>	
<b>Assistance with or performance of fecal disimpaction (manual disimpaction or multiple enemas)</b>	
<b>Continuous irrigation of eye using therapeutic lens (e.g. Morgan lens)</b>	
<b>Face to face patient education requiring more than 60 minutes.</b>	<i>Documentation will support the content of the education, time involved, and any factors that impacted on the time required. Examples include crutch training, diabetic teaching, counseling regarding diet, exercise, and other lifestyle changes.</i>
<b>Frequent monitoring/multiple assessments as evidenced by more than two sets of vital signs or assessments (including initial set), integral to current interventions and/or patient's condition.</b>	<i>Example: Additional vital signs, assessment of cardiovascular, pulmonary or neurological status, assessment of pain scale, pulse oxymetry or peak flow measurement.</i>
<b>Nasotracheal (NT) or orotracheal (OT) suctioning</b>	
<b>Wound care management (when not separately billable), not repaired – 51 sq. cm. or greater</b>	<i>Includes cleansing, assessment, measurement, photographing, ankle brachial index, and/or dressing of wound. Includes steri-strips and other adhesives, eye patch, butterflies. Note: For multiple wounds, add the total size of all wounds.</i>

# **Critical Care Model**

## Critical Care E/M Model 6/16/03

### Critical Care Interventions

**The following interventions qualify as critical care.** Additional explanations, examples and clarifications appear in italics. Items below as performed by hospital staff, rather than physician

<b>Interventions/care for critically ill or critically injured patients, e.g. central nervous system failure, circulatory failure, shock, renal, hepatic, metabolic, and/or respiratory failure. This may include, but is not limited to the following interventions:</b>	<i>Examples of critical ill or critically injured patients include: cardiopulmonary arrest or near arrest related to primary cardiac or respiratory causes, drug overdose, hyper/hypo-thermia, trauma (including severe burns), and other shock events such as anaphylaxis, diabetic shock, internal bleeding sepsis, etc.</i>
<b>Assist in induction/monitoring of pharmaceutical - induced coma</b>	<i>Examples: barbiturate coma for status epilepticus</i>
<b>Assist with rapid sequence intubation (that with provision/administration of sedative and/or paralytic agents), and/or airway management</b>	<i>Examples: AMBU, frequent ETT suctioning, set up for tube thoracostomy and assist physician with procedure, assist physician in performance of emergent cricothyrotomy, tracheostomy, endotracheal intubation, chest tube insertion, or any other emergency airway.</i>
<b>Code team/crash team/trauma team intervention</b>	<i>Multidisciplinary team approach to life or limb threatening situation. Some of the interventions will be separately billable, but this intervention requires additional facility resources with the activation and initiation of code interventions. Examples: performance of cardiopulmonary resuscitation, application and use of external, percutaneous or intracardiac pacemaker, set up for peritoneal lavage, resuscitation for hypothermia, CPR, defibrillation/emergent cardioversion, thoracotomy, pericardiocentesis.</i>
<b>Control of major hemorrhage such as for threatened exsanguination leading to hemodynamic instability</b>	<i>Control of hemorrhage for example for major trauma, post surgical, including monitoring, IV fluids, emergent administration of multiple concurrent blood products, etc.</i>
<b>Initiation, monitoring and titration of thrombolytic agents and vasopressors.</b>	<i>Monitoring and potential intervention for clinical instability in regard to vasoactive drips or push, antiarrhythmics for life-threatening arrhythmias (e.g. Nitroglycerin, Nitroprusside, dopamine, dobutamine, levophed, Isuprel, amiodarone, lidocaine, procainamide) and thrombolytic agents for acute myocardial infarction, strokes, pulmonary embolism (Streptokinase, TPA)</i>
<b>Continuous and on-going reassessment until stabilized, requiring immediate aggressive interventions in an unstable patient with potential for rapid deterioration and demonstrated instability.</b>	
<b>Post mortem C-section</b>	<i>Example: trauma pregnant woman who expires, emergency Cesarean section is performed to resuscitate and save the baby.</i>



# **The Panel**

## **FACILITY E/M EXPERT PANEL**

### **Co-Chairs:**

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Vice President, Policy  
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Dan Rode  
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### **Members:**

#### **American Hospital Association**

*The AHA is a not-for-profit association of health care provider organizations and individuals that are committed to the health improvement of their communities. The AHA is the national advocate for its members, which includes almost 5,000 hospitals, health care systems, networks, other providers of care and 37,000 individual members.*

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#### **American Health Information Management Association**

*AHIMA is a professional association that represents more than 45,000 specially educated health information management professionals who work throughout the healthcare industry. Health information management professionals serve the healthcare industry and the public by managing, analyzing, and utilizing data vital for patient care -- and making it accessible to healthcare providers when it is needed most.*

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#### **American College of Emergency Physicians**

*ACEP represents more than 22,000 members and is the largest and oldest emergency medicine organization.*

Robert W. Kottman, MD, FACEP  
Alamo Physician Services  
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#### **Emergency Nurses Association**

*The ENA nearly 23,000 members are staff nurses; ED nurse managers; administrators; clinical nurse specialists; pediatric, trauma, or flight nurses; prehospital coordinators; nurse practitioners; educators; and student nurses.*

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#### **American Organization of Nurse Executives**

*AONE is the nation's leading professional organization for nurses in leadership roles. Members include nurse executives, such as chief nursing officers, nursing directors and chief operating officers of health care facilities and systems; nurse managers; aspiring nurse*

leaders; consultants in nursing administration and management; graduate level nursing students in such areas as nursing, health care administration, business administration, and public policy; and deans, directors and faculty in graduate and undergraduate nursing programs.

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*(HCA--Approximately 200 hospitals and 70 outpatient surgery centers in 24 states, England and Switzerland. Investor-owned. Federation of American Hospitals – National representative of privately owned or managed community hospitals and health system throughout the United States.*

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*(The Florida Hospital Association is a not-for-profit association representing all types of hospitals throughout the state of Florida. FHA's membership includes over 230 hospitals, 20 Professional Membership Groups, and over 2,000 professional members. Member of the OPMTAG, NUBC, HFMA, and AHA's Coding Clinic for HCPCS Editorial Advisory Board)*

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