Problem-based charting (PBC): why now is the time

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UCHealth

Large integrated health network

- Community and Academic
- Community Connect
- FQHC

Stats

- 12 hospitals
- >5000 providers
- 450+ clinics
Our experience

- Ambulatory IT Governance
  - 26 years

- Sprint EHR Training and Optimization Program
  - 110 clinics
  - >1000 providers
  - >1000 staff

- Physician Builders
Agenda

Importance Problem List AND Provider Note

US and UCHealth Historical Context

How UCHealth achieved PBC

How UCHealth incorporated CMS billing changes
PBC requires a problem list

<table>
<thead>
<tr>
<th>DATE</th>
<th>#</th>
<th>PROBLEM OR CONDITION</th>
<th>PLAN</th>
<th>RESOLVED</th>
</tr>
</thead>
<tbody>
<tr>
<td>6/8/97</td>
<td>1</td>
<td>URTI with cough</td>
<td>cough syrup &amp; Codeine</td>
<td>8/97</td>
</tr>
<tr>
<td>4/2/00</td>
<td>2</td>
<td>hypertension</td>
<td>atenolol 50mg qd</td>
<td></td>
</tr>
<tr>
<td>6/8/04</td>
<td>3</td>
<td>Laceration (R) wrist -2&quot;</td>
<td>sutures -6</td>
<td>6/04</td>
</tr>
<tr>
<td>10/19/04</td>
<td>4</td>
<td>pain (L) hip x 3mo. ?osteochondritis</td>
<td>x-ray - ?/RA</td>
<td></td>
</tr>
</tbody>
</table>

PT. NAME: [Redacted]  D.O.B.: [Redacted]
Problem List defined

Amber’s definition:

*Any diagnosis that is actively managed* by someone (the patient, a specialist, a therapist, etc..) or something (a vitamin, a prescription, injections, etc…).

Rich and Heather astutely added:

*Any relevant diagnosis* that should remain in the forefront of the clinician mind as they diagnose and treat a given patient over time (breast cancer, chronic hemolytic anemia).

**Definition of Terms**

*Problem List* – A list of current and active diagnoses as well as past diagnoses relevant to the current care of the patient.
Problem List is key

We lack an organizing principle behind the patient chart

- Providers and staff to struggle to find patient information, spend a lot of time coordinating care
- Providers need to quickly close care gaps and survey chronic disease/medications in addition to patient concerns
- Patients view their messy problem lists on patient portals

For population health, research, and quality initiatives, we need discrete data

For interoperability, we need common datasets
Transformation of the provider note

Paper SOAP Note

EHR APSO Note
1) Cough (ICD-10: R05)
Patient coughing, nonproductive for one week. Worse at night. Sleeps with cat. Slight wheeze reported but exam normal. No fever or chills.

Differential diagnoses includes post-nasal drip/allergies (most likely), asthma, GERD, pneumonia (very unlikely).

Plan: Start nasal steroids. Advise cat sleeps in different area of home. If cough not resolving in one week, add antihistamine over-the-counter (zyrtec 10 mg by mouth daily). Consider allergy testing if not improving.

2) Type 2 diabetes mellitus with complication, without long-term current use of insulin (HC code) (ICD-10: E11.8)
Improved adherence to exercise plan. Walks 2 miles daily and lifts weights MWF for 30 minutes. Plant-based diet works best for her and she restarted one month ago. Recent home BG range fasting 80-105, postprandial 120-160. Hemoglobin a1c 7.6% on 10/30/2020. Reviewed diabetes educator notes from last week.

Assessment: Well-controlled diabetes.

Plan:
Due for eye exam and patient will schedule.
Continue prior treatment plan with semaglutide 0.5 mg once weekly.
ASA restarted after recent duodenal erythema found on EGD and treated.
Multiple discussions re: statin and patient declines use.

3) Hypertension associated with type 2 diabetes mellitus (HC code) (ICD-10: E11.59)
Blood pressure log past one week shows average daily BP 136/86. Patient is 100% adherent with medications. Stress level has been high due to election work. Caffeine intake also higher than normal - 2 cups coffee daily. She denies headache, chest pain, shortness of breath, dizziness, arm or jaw pain or any exertional symptoms including claudication.

Assessment: Uncontrolled hypertension in part due to recent stress and diet.

Plan:
Decrease to one cup coffee daily.
Consider meditation as means to deal with current stressors. Suggested meditation app, “the quiet place.”
Increase atenolol to 50 mg by mouth daily from 25 mg by mouth daily. Side effects and dosage routes discussed with patient.
Continue nifedipine for dual indication - Raynauds and hypertension.
Pharmacy visit one week for BP management.

Orders: AMB ENHANCED REFERRAL E-CONSULT TO CLINICAL PHARMACIST
Historical context

Medical practice and EHRs

- 1968: ICD9 expanded beyond cause of death
- 1977: Dr. Larry Weed published in NEJM “POMR”
- 1995-97: Billing guidelines: HPI, ROS, PE bullets/systems
- 2009: 50% of office-based physicians use EHRs
- 2010: HITECH Act
- 2015: ICD10 implemented
- 2017: CMS updated billing guidelines
- 2021: Increased consolidation of office-based practices

Rapid EHR adoption, EHRs support PL functionality

US Physician burnout 54%

Medical billing and coding

- 2009: Billing guidelines: HPI, ROS, PE bullets/systems
- 2015: ICD10 implemented
- 2017: CMS updated billing guidelines
- 2021: Increased consolidation of office-based practices
“Early adopters” need ”early majority” to buy into PBC
How did we achieve PBC success at UCHealth?

- Visionaries (2011-)
- Implementation Teams (PL) 2017-
- Custom PBC interface 2019-
- Implementation Teams (PBC) 2020-
- 2021 CMS billing changes 2021-
What took us so long to adopt PBC?

The product
Interface issues/usability
• Time spent in documentation and clinical review with PBC ≠ sufficient value to warrant changing habits

The people and process
• Workplace culture:
  • Siloed care
  • Avoidance of PL ownership
  • “Early adopters” need “early majority”
• Billing supported coding and not patient care prior to 2021
Usability and interface design

- Ease of use
- Workflow
- Minimal learning curve
- Consistency of location / muscle memory
- Expected behavior
Rich- do want to use any of this brainstorming?

We needed to make it easier to do the new thing:

• We lined up the problems for ease of viewing and dictation
• Epic added the ability to reorder diagnoses from the task bar
• Speech-recognition allows the user to continue talking while clicking down the list of problems
• We allow users to "copy forward" their last A/P
• We made it refreshable, so changes were easy
• You can see the last note in several places for chart review when you are dealing with inbasket items, telephone communication and visits.
• Users can easily see and add their Overview to their note and add any and all of this to their patient instructions, note and consult notes.
5/18/2021 visit with Altman, Richard Louis, MD for Confidential Visit

Visit Diagnoses

Essential hypertension

Problem List

Cardiac And Vascular

Unstable angina pectoris (ICD code)

Medications & Orders

Outpatient Medications

ImITDOne (DESYREL) 50 mg tablet

3 of 3 remaining


mefOMIN (GLUCOPHAG) 1,000 mg tablet

3 of 3 remaining


atovaSTAtin (LIPITOR) 40 mg tablet

3 of 3 remaining


Isopropyl, (PRINIVIL) 10 mg tablet

3 of 3 remaining


Calcium carbonate-vitamin D3 600 mg+400 unit per tablet


HYDROcodone-acetaminophen (NORCO) 5-325 mg

3 of 3 ordered

Patient Sign: Take 1 tablet by mouth every 4 hours as needed for Acute Pain. This med has acetaminophen (APAP). Ordered on: 1/25/2021. Authorized by: ALTMAN, RICHARD LOUIS. Dispense: 30 tablet.
### 5/18/2021 Visit with Altman, Richard Louis, MD for Confidential Visit

#### Visit Diagnosis: Essential Hypertension

**ICD-10-CM Code: I10**

#### Problem List

<table>
<thead>
<tr>
<th>Problem</th>
<th>Details</th>
<th>Code</th>
<th>Display Priority</th>
<th>Medium</th>
<th>Noted</th>
<th>Shared</th>
<th>KL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Essential Hypertension</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

**Overview:**
- **Altman, Richard Louis, MD**
- **5/13/2021**
- **2016:** Antidiuretic 5mg
- **2017:** Increase to Antidiuretic 10mg
- **2018:** Added Lisinopril 10mg
- **2019:** Bisoprolol 10, HCTZ 12.5mg
- **2020:** Increased to Antidiuretic 10, HCTZ 25mg
- **2021:** Consider AC

#### Medications & Orders

**Patient Reported**

**Review Open Orders**

**Outpatient Medications**
- **InfDIMone (Desyrel) 50 mg tablet**
  - **3 of 3 remaining**
  - **Patient Sig:** Take 1 tablet by mouth nightly at bedtime (for insomnia associated with depression). Ordered on 2/20/2021. Authorized by ALTMAN, RICHARD LOUIS.
  - Dispense: 90 tablet
- **MeFOMIN (Glicophase) 1,000 mg tablet**
  - **3 of 3 remaining**
  - **Patient Sig:** Take 1 tablet by mouth 2 times daily for type 2 diabetes mellitus. Ordered on 2/20/2021. Authorized by ALTMAN, RICHARD LOUIS.
  - Dispense: 180 tablet
- **AtivanSTAtin (Liptor) 40 mg tablet**
  - **3 of 3 remaining**
  - **Patient Sig:** Take 1 tablet by mouth daily for primary prevention of coronary heart disease. Ordered on 2/20/2021. Authorized by ALTMAN, RICHARD LOUIS.
  - Dispense: 90 tablet
- **Isosnirol (Prinivil/Lestril) 10 mg tablet**
  - **3 of 3 remaining**
  - **Patient Sig:** Take 1 tablet by mouth daily for hypertension. Ordered on 2/20/2021. Authorized by ALTMAN, RICHARD LOUIS.
  - Dispense: 90 tablet
- **Calcium Carbonate-Vitamin D3 600 mg-400 IU per tablet**
  - **3 of 3 remaining**
  - **Patient Sig:** Take 1 tablet by mouth daily. Ordered on 2/20/2021. Authorized by PROVIDER, HISTORICAL.
  - Dispense: 10 tablet
- **Hydrocodone-acetaminophen (NORCOD) 5-325 mg tablet**
  - **3 of 3 remaining**
  - **Patient Sig:** Take 1 tablet by mouth every 4 hours as needed for Acute Pain. This med has acetaminophen (APAP). Ordered on 2/20/2021. Authorized by ALTMAN, RICHARD LOUIS.

### Notes

- No problem-specific: Assessment & Plan notes found for this encounter.
5/18/2021 visit with Altman, Richard Louis, MD for Confidential Visit

Visit Diagnoses

Problem List
No visit diagnoses.

Medications & Orders

Outpatient Medications
- Atenolol (DESYREL) 50 mg tablet
  - 3 of 3 remaining
- Metformin (GLUCOPHAGE) 1,000 mg tablet
  - 3 of 3 remaining
- Ativan 3 mg tablet
  - 3 of 3 remaining
- Lisinopril (PRINIVIL/ZESTRIL) 10 mg tablet
  - 3 of 3 remaining
- Calcium carbonate-vitamin D3 600 mg-400 IU unit per tablet
  - 0 ordered
  - Patient Sig: Take 1 tablet by mouth daily. Ordered on 2/3/2021. Authorized by PROVIDER, HISTORICAL.

Current Assessment & Plan Note

Your Assessment & Plan specific to the problem

Stable. Continue with current regimen. Check labs at next visit.
Visit Diagnosis:
- Essential hypertension
- Tremor
- Viral upper respiratory tract infection

Overview:
- Patient with PD. Known to Dr. Lind.

Associated data (if available for diagnosis):

Current A/P:
- Stable but challenging for patient. To PT, follow with Dr. Lind.
Visit Diagnosis:

- Essential hypertension
- Tachycardia
- Viral upper respiratory tract infection

Overview:

Associated data (if available for diagnosis):

Current A/P:

With URI - do not think COVID, bacterial infection. Conservative care per patient instructions.
What took us so long to adopt PBC?

The product

Interface issues/usability

- Time spent in documentation and clinical review with PBC ≠ sufficient value to warrant changing habits

The people and process

- **Workplace culture:**
  - Siloed care
  - Avoidance of PL ownership
  - “Early adopters” need “early majority”

- **Billing** supported coding and not patient care prior to 2021

Address with optimization/implementation teams
Centralized optimization team

Help Ticket

Quick fix (reactive)

Burnout
Decentralized EHR optimization team
UCHealth institutes user-centered design with Implementation team and Sprint EHR optimization team
We teach:
Everyone owns the problem list

- We **add** diagnoses from visit AND from in basket
- We populate “overview” notes with relevant history
- We regularly participate in PL **clean up**
  - We don’t delete diagnoses that contain PBC
  - We don’t fear clean up, when in doubt, “resolve and add to PMH”
- Specialists **own problems in their body system**
- We **share** overview notes

**We educate and promote change:** the WHY and the what of PL/PBC
We ALL need to play in the sandbox

<table>
<thead>
<tr>
<th>Neuro</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>- Altered mental status</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Altered mental status, unspecified altered mental status type</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Dementia associated with other underlying disease with behavioral disturbance (HC code)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Intracranial hemorrhage (HC code)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Late onset Alzheimer’s disease without behavioral disturbance (HC code)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overview: Patient concern that he is a longterm musician and cannot recall pieces as well as in the past, cannot r...</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Left-sided Bell’s palsy</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
We promote:
Problem list clean up

• At UCHealth, we:
  • Purchased software to accurately sort by body system
  • Kept PMH and outside information separate from internal PL
  • Use CDS to warn user when adding duplicate problem

You could consider these actions (not done at UCHealth):
- auto-expire short term dx
- auto-resolve problems not addressed in given time period
We support:
New CMS guidelines as an opportunity to be doctors again!

1995 and 1997 billing guidelines led to:

- Significant **time counting bullets** for HPI, ROS, PE charting
- **Overuse of templates and data tables** to justify billing
- Little time left to document patient story and extensive treatment plan

2021 billing guidelines allow us to:

- Focus on time spent, severity of illness, assessment and plan
Have we had success at UCHealth?

Visionaries 2011-

Implementation Teams (PL) 2017-

Custom PBC interface 2019-

Implementation Teams (PBC) 2020-

2021 CMS billing changes 2021-
PBC data over time 2019-present

New PBC interface
Data for New Implementations

STRIDE Outpatient 4/2020 - 2/2021
PBC uses / week

Number of PBC uses
Implementation
Data for Sprinted clinics

AMC Neurology Outpatient 8/2020 - 5/2021
PBC uses / week

![Graph showing PBC uses over time with a sprint indicated on the x-axis.](image-url)
2021 CMS Billing Updates
Right time, right place

1. **PBC** gained momentum with Sprint optimization team (late 2019)
2. **Desire for standard note** grew as need for attestations increased with telehealth – “optional smarttool” (4/2020)
3. **PBC** rolled out with new EHR implementation in large FQHC group (June 2020)
4. **Desire for standard note** increased more when it contained up-to-date billing guidance – “ghost text” (1/2021)
5. Appetite for simplicity during/after pandemic
## Change in CMS guidelines for medical billing

<table>
<thead>
<tr>
<th>Before Jan 2021</th>
<th>After Jan 2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Billing based on history, physical exam, data and MDM elements</td>
<td>Billing based on MDM</td>
</tr>
<tr>
<td>OR</td>
<td>OR</td>
</tr>
<tr>
<td>Billing based on time (50% spent in counseling and coordination of care)</td>
<td>Billing based on time (time spent on day of service on this patient)</td>
</tr>
</tbody>
</table>
We take opportunity to re-introduce a standard note

<table>
<thead>
<tr>
<th>Assessment and Plan:</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ASSESSMENT/PLAN:2103000045]</td>
</tr>
</tbody>
</table>

**Subjective:**

Patient ID: Florencio Florencio is a 67 y.o. male who presents to CU Denver Internal Medicine Group for chief complaint on file.

**HPI**

[Advance Care Planning (Optional):2109012345]

**Current Medications:**

<table>
<thead>
<tr>
<th>Current Ongoing Medication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tramadol (PRIMAT, ZESTRIL) 20 mg tablet</td>
</tr>
<tr>
<td>LORAZepam (ATIVAN) 1 mg tablet</td>
</tr>
</tbody>
</table>

No current facility-administered medications for this visit.

**Allergies:** Patient has no known allergies.

**UPI PAST FX:2103000060**

**Review of Systems**

**Objective**

There were no stats taken for this visit.

**Physical Exam**

**DATA:**

[MISC: UP DATA:20018]

**TIME/COUNSELING:**

[UPICOMM:2103000027]

Telehealth attestation statement: 36611

Eden Fleming, MD

---

<table>
<thead>
<tr>
<th>Assessment and Plan:</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ASSESSMENT/PLAN:2103000040]</td>
</tr>
</tbody>
</table>

**Subjective:**

Florencio is a 67 y.o. male who presents to CU Denver Internal Medicine Group for chief complaint on file.

**HPI**

[Advance Care Planning (Optional):2109012345]

**Review of Systems**

**Objective**

There were no stats taken for this visit.

**Physical Exam**

**DATA:**

[MISC: UP DATA:20018]

**TIME/COUNSELING:**

[UPICOMM:2103000027]

Telehealth attestation statement: 36611

Eden Fleming, MD
How can the EHR help?

Standard note helps with billing, compliance
1. **Optional time statement** suggests time in ghost text
2. **EHR detects telehealth visits** and suggests attestation

**EHR calculates time** spent in chart

**EHR calculates your time** in the chart
<table>
<thead>
<tr>
<th>Level</th>
<th>Problems Addressed</th>
<th>Amount and/or Complexity</th>
<th>Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>1 Self-limited or minor problem</td>
<td>Minimal or None</td>
<td>Minimal</td>
</tr>
<tr>
<td>3</td>
<td>2 or more self-limited or minor problems</td>
<td>Limited                                    &lt;br&gt;Any combination of 2:  &lt;br&gt;Review of prior external notes from unique source  &lt;br&gt;Review of the results from each unique test  &lt;br&gt;Ordered of each unique test  &lt;br&gt;or  &lt;br&gt;Assessment requiring an independent historian</td>
<td>Low  &lt;br&gt;- OTC drugs  &lt;br&gt;- Minor surgery with no identified risk factors</td>
</tr>
<tr>
<td>4</td>
<td>1 or more chronic illness with exacerbation, progression, or side effects of treatment  &lt;br&gt;2 or more stable chronic illnesses  &lt;br&gt;1 undiagnosed new problem with uncertain prognosis  &lt;br&gt;1 acute illness with systemic symptoms  &lt;br&gt;1 acute complicated injury</td>
<td>Moderate (one from below)                             &lt;br&gt;- Tests, documents, or independent historians  &lt;br&gt;- Independent interpretation of tests  &lt;br&gt;- Discussion of management or test interpretation</td>
<td>Moderate  &lt;br&gt;- Prescription drug management  &lt;br&gt;- Minor surgery with identified risk factors  &lt;br&gt;- Elective major surgery with no identified risk factors  &lt;br&gt;- Diagnosis or treatment significantly limited by social determinants of health</td>
</tr>
<tr>
<td>5</td>
<td>1 or more chronic illness with severe exacerbation, progression, or side effects of treatment  &lt;br&gt;1 acute or chronic illness or injury that poses a threat to life or bodily function</td>
<td>Extensive (two from below)                             &lt;br&gt;- Tests, documents, or independent historians  &lt;br&gt;- Independent interpretation of tests  &lt;br&gt;- Discussion of management or test interpretation</td>
<td>High  &lt;br&gt;- Elective major surgery with identified risk factors  &lt;br&gt;- Emergency major surgery  &lt;br&gt;- Drug therapy requiring intensive monitoring for toxicity  &lt;br&gt;- Decision not to resuscitate or to de-escalate care because of poor prognosis  &lt;br&gt;- Decision regarding hospitalization</td>
</tr>
</tbody>
</table>

Medical Decision Making Level: 2  
Time Level: None selected  
Code to be added: 99212 PR. OFFICE/OUTPT VISIT, EST., LEVL II [99212 CPT®]  
© 2021 Epic Systems Corporation
With slimmed down notes and less restrictive billing guidelines, we can be clinicians again and spend our time on PBC!
Thank you for your time

Any questions?

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Heather.Holmstrom@cuanschutz.edu

Rich Altman, MD
Richard.Altman@cuanschutz.edu
# MDM Requirements

<table>
<thead>
<tr>
<th>Code</th>
<th>Level of MDM (Based on 2 out of 3 Elements of MDM)</th>
<th>Number and Complexity of Problems Addressed</th>
<th>Elements of Medical Decision Making Amount and/or Complexity of Data to be Reviewed and Analyzed</th>
<th>Risk of Complications and/or Morbidity or Mortality of Patient Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>99202</td>
<td>Straightforward</td>
<td>Minimal</td>
<td>Minimal or none</td>
<td>Minimal risk of morbidity from additional diagnostic testing or treatment</td>
</tr>
<tr>
<td>99212</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 99203 | Low | Low | Limited (Must meet the requirements of at least 1 of the 2 categories) Category 1: Tests and documents • Any combination of 2 from the following:  
  • Review of prior external note(s) from each unique source*;  
  • Review of the result(s) of each unique test*;  
  • Ordering of each unique test*  
  or  
  Category 2: Assessment requiring an independent historian(s) (For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high) | Low risk of morbidity from additional diagnostic testing or treatment |
| 99213 | | | | |
| 99204 | Moderate | Moderate | Moderate (Must meet the requirements of at least 1 out of 3 categories) Category 1: Tests, documents, or independent historian(s) • Any combination of 3 from the following:  
  • Review of prior external note(s) from each unique source*;  
  • Review of the result(s) of each unique test*;  
  • Ordering of each unique test*  
  or  
  Category 2: Independent interpretation of tests • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);  
  or  
  Category 3: Discussion of management or test interpretation • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported) | Moderate risk of morbidity from additional diagnostic testing or treatment |
| 99214 | | | | |
| 99205 | High | High | Extensive (Must meet the requirements of at least 2 out of 3 categories) Category 1: Tests, documents, or independent historian(s) • Any combination of 3 from the following:  
  • Review of prior external note(s) from each unique source*;  
  • Review of the result(s) of each unique test*;  
  • Ordering of each unique test*  
  or  
  Category 2: Independent interpretation of tests • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);  
  or  
  Category 3: Discussion of management or test interpretation | High risk of morbidity from additional diagnostic testing or treatment |
| 99215 | | | | |