History of CPT

- CPT Advisory Committee objections (cont)
  - Suggest revisions to CPT
  - Assist in reviewing and further development of relevant coding issues to prepare technical education material and articles pertaining to CPT
  - Promote and educate members on the use and benefits of CPT


- Third and Fourth Editions published in mid-1970's

- 1983, HCFA (now CMS) adopted and mandated CPT as part of the Healthcare Common Procedure Coding System (HCPCS) for reporting Medicare Part B services

History of E&M

- Prior to 1992, physicians billed with a series of codes known as levels found in the CPT “Medical Services” section.

- Just like today, there were wide variations and interpretations in using these codes.
History of E&M

For established office and subsequent hospital care, the levels available were:

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<td>90080</td>
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</table>

History of E&M

• E&M first appeared in the CPT in 1992

• The only guidelines were those contained in the CPT manual.

History of E&M

• First “official” guidelines were published by HCFA (aka CMS) in 1995 and again in 1997.

Overview

An E&M service is an encounter between a provider and a patient that typically includes face-to-face time. Most E&M services are used to report “acute or sick” patient encounters.

95/97 guidelines: Main difference
  97 allows the 3 C rule in the HPI
  97 Examination are based on bullet outlines through specific system examinations.

What are you billing for?

• New / Established Patient
• New Patient
• Critical Care
• Observation / Inpatient / Discharge

General Information

There is no crosswalk or conversion between the previous levels of service codes and the new E/M codes. The new E/M codes were placed in an entirely new section of CPT entitled “Evaluation and Management Services” to further emphasize these differences. While the physician is still providing the same kinds of services (e.g., examinations, evaluations, treatments), the method of determining which level of E/M service to report is quite different than in the past.

CPT Assist, Winter 1991
Definition of New Patient

“...one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years.”

Definition of an Established Patient

“...one who has received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years.”

Definition of Critical Care

- The amount of time spent by the physician in activities performed at the bedside or on the floor which are directly related to the critically ill or injured patient’s care may be reported as critical care.
- Documentation must include a summary of the activities performed by the physician and the total amount of critical care time spent.
- When the patient is unable or clinically incompetent to participate in discussions, time spent on the floor or unit with family members or surrogate decision makers obtaining a medical history, reviewing the patient’s condition or prognosis, or discussing treatment or limitation(s) of treatment may be reported as critical care, provided the conversation bears directly on the management of the patient.
- Documentation must state which vital organ is impaired such that there is a high probability of imminent or life threatening deterioration in the patient’s condition.

Observation

- 99218-99220 Observation for less than 8 hours, no discharge code billed.
- 99218-99220 1st day initial observation
- 99217- day discharged from observation
- 99201-99205/99211-99215 for day 2 or 3 on the rare cases that a pt is in observation for multiple days
- 99234-99236 – same day admission and discharge from observation or inpatient

Inpatient

- 99221-99223 – Initial Hospital Care- used to report the 1st hospital inpatient encounter with the patient by the admitting physician
- 99231–99233 – Subsequent Hospital Care – all levels of subsequent hospital care include reviewing the medical record and reviewing the results of diagnostic studies and changes in the patient’s status since the last assessment by the physician.

Discharge

- 99238-99239 – Discharge Services – codes includes, as appropriate, final exam discussion of hospital stay, instruction for continuing care to all relevant caregivers, preparation of discharge records, prescriptions and referral forms.
  - 99238 - 30 minutes or less
  - 99239 - more that 30 minutes, time must be documented.
Billing Based on Time

- Outpatient: face-to-face time in room
- Inpatient: floor/unit time

Using The 3 Key Components

- New/Consult visits – the 3/3 rule
- Established/FU visits – the 2/3 rule
- Check the code descriptor of any code within the category to see which rule applies

Documentation Requirements for Time Based Codes

- Total time
- Counseling
- Subjects discussed (or care coordination activities performed)

The Chief Complaint (CC)

- AKA the “reason for the visit”
- “a concise statement, usually in the patient’s own words, describing…”
- Must be documented for every encounter

Documentation Requirements for Time Based Codes

- Time may be used to report the level of service when greater than 50% of the total length of time of the encounter (face-to-face or floor time, as appropriate) is spent in counseling and/or coordination of care. Time must be documented and the record along with a summary of the counseling and/or activities to coordinate care.
- The CPT book describes counseling as a discussion with the patient and/or family concerning one or more of the following:
  - Diagnostic results, impressions, and/or recommended diagnostic studies
  - Prognosis
  - Risk and benefits of management (treatment) options
  - Instructions for management (treatment) and/or follow-up
  - Importance of compliance with chosen management (treatment) options
  - Risk-factor reduction
  - Patient and family education

Selecting the Level of Service

- A. Using the 3 key components
  1) History
  2) Exam
  3) Medical Decision Making
- B. Using Time
History of Present Illness

DESCRIPTORS

• Location – Site of condition
• Quality – Usually an Adjective
• Severity – May be overt - pain scale 1–10, moderate, mild, sharp. Can also be inferred – child with pain, up all night crying. May include staging.
• Modifying factors – What helped to deal with the condition?
• Duration – How long?
• Timing – When does the condition occur?
• Context – What happened? The Big Picture.
• Associated Signs and Condition – Pertinent positives and negatives to the Chief Complaint.

Test your HPI skills

1. Mr. Smith complains of a 2-day history of a worsening sore throat for which he has taken sudafed.
2. Larry returns today with a 2 month history of low back pain. He has been taking ibuprofen every 4 hours, and the pain is rated as a 7 on the Liebert pain scale.

Test your HPI Skills

• CC: Mrs. Jones is here for follow-up on multiple medical problems:
  1. Hypertension: patient taking her medication with no chest pain or headache
  2. Diabetes: finger sticks in the am are 110-130. Taking 2 extra units regular at night
  3. Elevated cholesterol: taking zocor, watching diet, no muscle pain

Review of Systems (ROS)

• “General inventory of body systems seeking to identify signs and/or symptoms” experienced by the patient

Review of Systems (ROS) Levels

• Problem-pertinent ROS= positive/pertinent negative responses for the system related to the CC
• Extended ROS= findings for 2-9 systems
• Complete ROS= finding for at least 10 systems

Review of Systems (ROS)

• Complete ROS Documentation:
  • “Those systems with positive or pertinent negative responses must be individually documented. For the remaining systems, a notation indicating all other systems are negative is permissible.”
Pre-Conference Workshop

Test your ROS Skills

Pt comes in with a CC of shortness of breath
1. Positive for cough and wheezing
2. Negative for congestion
3. Decreased appetite over past week
4. All other systems negative

Test your ROS Skills

1. The patient denies fevers, chills, vomiting, diarrhea, diplopia, muscle cramps, headaches or dyspnea.
2. The patient reports pain in the breast upon palpation with some mild drainage, otherwise all other systems are negative.

Past, Family, Social History (PFSH)

- Patient's PAST Medical History
- Patient's Family's Past Medical History
- Patient's SOCIAL History

PFSH-PAST Medical History

- Prior major illnesses and injuries
- Prior operations
- Prior Hospitalizations
- Current Medications
  (often documented in a separate field from other PMH)
- Allergies
- Immunization status
- Feeding/dietary status

PFSH - FAMILY History

- Health status or cause of death of immediate family members
- Specific diseases related to problems identified in the CC, HPI and/or ROS
- Diseases of family members that may be hereditary or place the patient at risk

PFSH – SOCIAL History

- Marital status and/or living arrangements
- Current employment
- Occupational history
- Use of drugs, alcohol and tobacco
- Level of education
- Sexual history
- Other relevant social factors
ROS and PFSH Allowances

- ROS/PFSH obtained at a prior encounter does not need to be re-recorded if there is evidence that the provider updated the information.
- ROS/PFSH may be recorded by ancillary staff.

Test your PFSH Skills

- The patient has informed me that his father has prostate cancer.
- Child has a caregiver that smokes.
- Patient has no allergies and is on no current medication at this time.

General Guidelines for Examination Documentation

- Documentation of the examination must be complete and legible.
- Documentation should occur during or as soon as possible after exam is performed to maintain accuracy.
- Identity of examiner must be evidenced in documentation (hand written, unique electronic identifier).

General Guidelines for Examination Documentation, cont.

- Any addenda should be dated the day information is added, rather than date service was rendered.
- Medical records cannot be altered—corrections should be made with a single line drawn through the error, then signed (or initialed) and dated. For electronic an addendum should be added with the date the addendum was made not the actual date of service.

95 / 97 Guidelines

The examination is the biggest difference between the 95 / 97 guidelines.

97 guideline is more stringent than the requirements for the 95 guidelines.

97 examinations are based on number of bullets only.

The 3C rule is allowed in the HPI—depending on your carrier some will allow in the 95 guidelines.

Types of Examinations

- **Body Areas**
  - Head, including the face
  - Neck
  - Chest, including breasts and axillae
  - Abdomen
  - Genitals, groin and buttocks
  - Back, including the spine
  - Each extremity

- **Organ Systems**
  - Constitutional*
  - Eyes
  - Ear, Nose, Mouth and Throat
  - Cardiovascular
  - Respiratory
  - Gastrointestinal
  - Genitourinary
  - Musculoskeletal
  - Skin
  - Neurologic
  - Psychiatric
  - Hematologic/Lymphatic/Immunologic

*This is not listed as an organ system in CPT, but was listed as a system for purpose of examination by CMS in their documentation guidelines.
Test your Exam skills

- Chest clear to auscultation.
- Cardiovascular: Regular rate S1 and S2
- Extremities: No clubbing, cyanosis, or edema.
- Neurologic: there are no focal deficits. He recalled 15 on category item recall of animals. He was 3/3 for animal recall.

Elements of Medical Decision Making

- Determining the overall level of Medical Decision Making is based on the complexity of 3 variables:
- Number of possible diagnoses and management options
- Amount and complexity of diagnostic testing ordered/data reviewed
- Associated risks to the patient of significant complication, morbidity, and/or mortality

Documenting Medical Decision Making

- Determining the level of **history** and **exam** is an **objective** process based upon explicit guidelines
- Determining level of **medical decision making** is a **subjective** process in which a coder must attempt to evaluate documentation with non-explicit guidelines

Diagnoses / Management Options

- # **DX** points – does not refer to the absolute number of diagnoses but to the complexity of the diagnoses
- 5 categories and each is assigned a point value
- Number of points are cumulative, but maximum is 4

Quantifying Medical Decision Making

- Of the 3 key components of E/M services, medical decision making is most difficult to quantify
- History and exam have specific numeric requirements that facilitate determining the level
- Medical decision making requirements are open to interpretation: “**minimal**, “**limited,**” "**multiple,**” etc. are **subjective** terms

Amount and/or Complexity of Data to be Ordered/Reviewed

- Based upon:
- Types of diagnostic tests ordered or reviewed
- Request and review of old medical records
- Necessity for obtaining history from a source other than patient
  - Level can be minimal, limited, multiple or extensive
Risk of Significant Complications, Morbidity, and/or Mortality
Determining this level is based upon:

- Risks associated with presenting problem(s)
- Risks associated with diagnostic procedures performed
- Risks associated with management options
  - Level of risk can be minimal, low, moderate, or high

Risk of Significant Complications, Morbidity, and/or Mortality, -cont.

- Factors indicating increased level of risk of significant complications, morbidity, and/or mortality include:
  - Increased number and severity of co-morbidities/underlying diseases
  - Any surgical or invasive diagnostic procedures that are planned
  - Referral or decision to perform a surgical or invasive diagnostic procedure on an urgent basis

Test your MDM Skills
- Strep Pharyngitis
  1. Rapid Strep test in office was +
  2. Start on Pen VK 500 mg 250mg/5 ml t.i.d.x 10 days.
  3. Soft bland diet, progress slowly as tolerated
  4. Take antibiotic with food.
  5. Notify office if symptoms are not improving over the next 48 hours.

Test your MDM Skills
- Left knee sprain/straining – new problem
  - At this point I feel the physical therapy and continued conservation care is appropriate. Should she not continue to improve with PT or should she find that her pain is getting worse, she is to follow-up for re-evaluation and possible MRI.

Test your MDM skills
- Impression:
  - Inguinal Hernia
  - Diabetes
  - Hypertension

James presented today with acute abdominal pain. The patients KUB reveals a rather large inguinal hernia that will need surgical intervention. We will schedule him with a general surgeon for the first thing in the morning.

Bringing it All Together
- New/Initial visits – the 3/3 rule
- Established/FU visits – the 2/3 rule
Putting it all Together

UTI – established pt
55 year old female c/o abdominal pain and dysuria for 4 days. It has gotten worse today and she feels she has to urinate every 1/2 hour. She denies fever, flank pain, nausea, vaginal discharge.

Meds none
All FON
Social history: monogamous with husband
Exam: V: 120/80, 80, 12, T 99F
Gen: NAD
CVR: RRR, no murmurs
Lungs: clear BS blt.
Abdomen: soft, BS+, mild suprapubic tenderness, no rebound masses, guarding.
UA WBC: tntc
Assessment: Acute Cystitis
Plan: Bactrim

NEW / INITIAL

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<th>Problem Focused</th>
<th>Expanded Problem Focused</th>
<th>Detailed</th>
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Established / Subsequent

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Sources

- National Committee for Quality Assurance www.ncqa.org
- 1997 Documentation Guidelines for Evaluations and Management Services, Center for Medicare and Medicaid (CMS) www.cms.hhs.gov
- 1995 Documentation Guidelines for Evaluations and Management services, Center for Medicare and Medicaid (CMS) www.cms.hhs.gov
- CPT Assistant, American Medical Association, May 2006, Volume 16 Issue 5, pg2
- 3M
- MediSync

AUDIT REPORTING AND FOLLOW UP

What now?

- Items or issues other than the level to report on (cont):
  - Were other CPT codes on the superbill correct
  - Was the documentation legible
  - Did the provider sign and date the documentation
  - Did the CPT from the superbill match the patient accounting system and the claim

Know the Issues being looked at

- OIG Work Plan www.oig.hhs.gov
- MAC Focuses
- RAC Audits www.cms.gov/RAC/01_Overview.asp
- CMS Postings www.cms.gov

AUDIT REPORTING AND FOLLOW UP

Don’t forget your Medicaid Manuals!
AUDIT REPORTING AND FOLLOW UP

Summary:
• Stick to what you are looking for but note incidental findings that might be beneficial to your employer
• Read and understand the regulations pertaining to what you are auditing
• Be detailed in your audit worksheets

Patient List
Obtain a list of all patients that meet the criteria of your audit objectives, such as
– Payor type
– Date of service range
– E&M level, if specified
– Provider, if specified

Your audit may be for specific charts, and in those cases, it would be appropriate to have the charts given to you.

These situations could include:
– Auditing a specific provider for a specific day
– Auditing a specific issue
AUDIT REPORTING AND FOLLOW UP

Recording and Calculating Your Results

Things to Remember

• Verify all criteria you were tasked with are included
• Don’t add fluff — if it isn’t needed, don’t include it
• ALWAYS make sure your cell numbers and formulas are CORRECT!

Another Example

Example: “Audit the E&M level in five charts of Dr. X”

You audited five charts for E&M levels and found the following:

- Three charts billed 99213 and documentation supported 99213
- One chart billed 99212 and documentation supported 99213
- One chart billed 99213 and documentation supported 99212
AUDIT REPORTING AND FOLLOW UP

Account | Patient Last Name | Date of Service | Office E&M CPT Code | Auditor E&M CPT Code | Documentation Supports E&M CPT Billed or Lower
--- | --- | --- | --- | --- | ---
121212 Smith | 8/17/2010 | 99213 | 99213 | 100%
676767 Jones | 8/2/2010 | 99213 | 99213 | 100%
272727 Waters | 8/3/2010 | 99213 | 99213 | 100%
131313 Carter | 8/4/2010 | 99213 | 99212 | 0%
103103 Williams | 8/18/2010 | 99212 | 99213 | 0%

Physician Score: 60%

Time for Hands on Practicing!

Writing Up the Report

Elements of the Report

- Title
- Audit dates
- Report date
- Executive Summary
AUDIT REPORTING AND FOLLOW UP

- Executive Summary
  - Background
  - Purpose
  - Scope
  - Key Observation
  - Recommended action plans
- Optional: Detailed Observations And Recommendations

EXECUTIVE SUMMARY

BACKGROUND

Provider is a participant with the Medicare program and therefore is required to follow the rules, regulations and guidelines published by the Centers for Medicare and Medicaid Services (CMS) regarding coding practices. Administrator X requested an audit of E&M services charged by the providers.

PURPOSE

The objective of this audit will be to determine compliance in the assignment of E&M CPT codes for office services.

SCOPE

A total of 70 charts were reviewed. 10 charts per provider were submitted.

KEY OBSERVATIONS

- Audits have been conducted on the new patient and consultation CPT codes but not established codes.
- Some reports received had the print date listed where the service date should be.
- The reports from procedures appear to pull some ICD-9 diagnosis codes from the impression and indications.
- It could not always be determined if the referring physician received a report of the findings from the consultant. Reporting back to the referring physician is a requirement for billing the consultation CPT codes (99241-99245).
- Some diagnoses were not coded as described in the documentation.
- No pathology reports for removed polyps were seen during this review.

RECOMMENDATIONS

- Consider an audit of established E&M CPT codes (99212-99215)
- Verify that the correct date of service is in the medical records.
- Verify that the ICD-9 diagnosis codes listed on the procedure reports under the ICD-9 Code section are reviewed prior to being assigned to the claim. These codes were not the same as seen on the printed report provided for this review.
- Consider adding to the documentation a statement confirming that the referring physician did receive a copy of the findings from the consultant.
- Consider education on ICD-9 diagnostic coding, especially unspecified vs. other specified. Also may want to keep in mind the upcoming ICD-10 implementation. ICD-10 is a more detailed diagnostic coding system.
- Verify that the ICD-9 diagnostic codes being assigned for polyps are correct as is. Consideration may need to be given to waiting for the pathology report before coding.
- Review the 2009 OIG workplan to identify any areas under review. Consider an audit of those areas or services that may be of concern.
- Consider shadowing the providers to verify documentation in the chart is occurring during the patient encounter.
- This report is submitted as a summary of the findings. Please refer to the specific reports for details of each account reviewed.

Freda Brinson, CPC, CPC-H, CEMC
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<th>Date</th>
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**Triage Notes**

- **Chief Complaint**: Difficult and little reason even fall
- **OBS**: Good lab values except for back pain
- **Medical History**: History of back pain
- **Physical Exam**: No abnormalities

**Physical Exam**

- **Vitals**: ABG's, labs, and vitals were normal
- **CV**: No murmurs or bruits
- **ABD**: No tenderness or masses

**Diagnosis**

- **Diagnosis**: Hypothyroid
- **Plan**: 1. No treatment for hypothyroid
   - 2. COPO
   - 3. Treatment & care
   - 4. Lab workup and review on return
   - 5. On discharge
   - 6. Physician follow-up
   - 7. Discharge

**Medication**

- **Medication**: None

**Allergies**

- **Allergies**: None
REASON FOR VISIT: Six month followup.

HISTORY OF PRESENT ILLNESS: The patient is a 65-year-old white female C4, P4, 0-0-4 who is status post LA VHD/BSO and pelvic lymph node dissection on 9-8-09 for a IB adenocarcinoma of the endometrium with grade II. She comes in today with no complaints. She denies any pain. She denies any vaginal bleeding and bladder habits are normal. She has no complaints of dysuria or frequency of urination. At her postoperative appointment she reported some serosanguinous ooze from the navel with a little bit of erythema, this has completely cleared up. She has no residual complications from her surgery. Of note, she has recently moved and otherwise her history is unchanged.

PAST MEDICAL HISTORY: Significant for type II diabetes, hypertension, hypercholesterolemia, and history of diverticulitis in 2006. She had a stroke with ocular changes back in 2002 and glaucoma, which has been evaluated by Dr. Ryten.


FAMILY HISTORY: The patient's mother died at age 79 of hypertension and stroke. Father died at age 65 with emphysema.

SOCIAL HISTORY: She recently moved to Effingham, GA but makes frequent trips back to Savannah to visit her children. She is currently divorced. She is currently retired from the insurance office at Memorial University Medical Center. She is currently not sexually active. She denies alcohol, tobacco or illicit drug use.

MEDICATIONS: Daily aspirin, clopidogrel, Hyzaar and potassium supplement.

ALLERGIES: She has no known drug allergies.

REVIEW OF SYSTEMS: The patient filled out a 14-point review of systems dated 4-9-18 and placed in the progress note section of her chart. It is positive for diabetes and hypertension medications. The rest of the systems were noted to be negative.

PHYSICAL EXAM:

WT: 230.8
HT: 101/89
T: 97.0
P: 92
R: 30

GENERAL: She is a well-developed, well-nourished white female in no apparent distress. She is alert and oriented x 4.

NECK: Within normal limits

LYMPH NODES: Demonstrated no lymphadenopathy noted in the supraventricular, cervical, axillary or inguinal regions.

DREANEY:

LUNGS: Clear to auscultation in all fields assessed. Good respiratory effort and no wheezes or rales.

HEART: Regular rate and rhythm without murmur, rub or gallop.

ABDOMEN:

Soft, protuberant, slightly obese with well-healed incision sites from her laparoscopic procedure. No HSM. No evidence of hernia. Bowel sounds were noted to be normal.

EXTREMITIES:

Demonstrated no clubbing, cyanosis or edema

SKIN:

Demonstrated no rashes and normal skin texture.

PELVIC:

NEG:

VAGINA:

Smooth, atrophic without ulcerations. There is a well-healed vaginal cuff.

Bimanual/rectovaginal:

Demonstrated a smooth vaginal mucosa with an intact vaginal cuff. The uterus, cervix and ovaries are surgically absent. There is no nodularity. Anal tone was normal and rectovaginal was confirmed.

IMPRESSION/PLAN:

1. Stage IB grade II endometrial adenocarcinoma. The patient will continue to followup with return visit every six months. We obtained a pap smear today and will followup the results of this.
2. Aortic valve replacement: This is followed by her primary medical doctor.
3. Type II diabetes: Patient is on Clopidogrel and reports being well controlled.
4. Hypertension: Patient is under control at this point in time.