BASIC DOCUMENTATION AND COMPLIANCE EDUCATION

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UK Office of Corporate Compliance

Outline

- What is the importance of correct documentation and coding?
- What are the documentation guidelines?
- What are the key elements of an E/M?
- Coding initial and subsequent inpatient visits.
- Critical Care documentation and coding.
- Using Modifier-24 in the Post-op Global Period.
- Tips for EHR documentation.

What is the Importance of Correct Documentation and Coding?

- Documentation determines the appropriate code and by extension the reimbursement for a service
- Most common coding mistakes include:
  - Downcoding- undercharging for the services rendered
  - Upcoding- overcharging for the services rendered

- **Both can trigger an audit!!**

Documentation Guidelines

- Notes should be dated, signed, and timed when appropriate
- The reason for the visit, all tests, and procedures ordered should be documented to support medical necessity
- Procedure notes should support CPT code billed
- Documentation and signature should be legible
- **Remember, if it is not documented, it did not happen!**

Inpatient E/M Services

- Initial Hospital Care, Observations, and Consultations require all 3 key components

Key Components of Inpatient E/M Services

- History
  - Chief Complaint
  - History of Present Illness (HPI)
  - Review of Systems (ROS)
  - Past Medical, Family, Social History (PFSH)
- Physical Exam
- Medical Decision Making
  - Number of diagnoses or management options
  - Amount and/or complexity of data reviewed or ordered
  - Risk of complications and/or morbidity or mortality

Chief Complaint

- The chief complaint is traditionally the reason for the visit, usually stated in the patient's own words briefly describing his/her symptom, problem, or condition.
- The CC is required for all E/M codes.

History of Present Illness (HPI)

- The HPI is a timeline describing the patient's current illness from the first symptom(s) to the present' usually in the patient's own words

- There are 8 elements included in the HPI

HPI Elements

- Location- where problem, pain, or symptoms occur
- Quality- description of problem, symptom, or pain
- Severity- description of severity of symptom or pain
- Duration- how long problem, symptom, or pain has persisted
- Timing- when a problem, symptom, or pain occurs
- Context- instances that can be associated with the problem, symptom, or pain
- Modifying Factors- actions taken to make the problem, symptom, or pain better or worse
- Associated Signs and Symptoms- other problems, symptoms, or facts that occur when primary problem, symptom, or pain occurs

HPI Examples

From : *AMA Medical Record Auditor, 2nd Edition* By: Deborah Grider

- "Patient's cough is nonproductive and "nonbarky" and has worsened today. Patient also has rhinorrhea, which began yesterday"
  - Location: "cough"
  - Quality: "nonproductive"
  - Context (or) Modifying Factors: "nonbarky and has worsened today"
  - Associated Signs and Symptoms: "rhinorrhea"
- 4 elements identified—Extended HPI

Review of Systems (ROS)

- The ROS is generally a series of questions and answers related to the patient's complaints as stated in the Chief Complaint and History of Present Illness
- The ROS may be recorded by ancillary staff or the patient as long as it is referenced in the chart note by the physician

Review of Systems (ROS)

- Constitutional
- Eyes
- Ears, Nose, Mouth, Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary
- Neurological
- Psychiatric
- Endocrine
- Hematologic/ Lymphatic
- Allergic/immunologic

Review of Systems (ROS)

- **All Hospital Observation Services, Initial Hospital Care Services, and Inpatient Consultations require a ROS.**
- The ROS is the most often overlooked portion of the history. Without a ROS no E/M code for these services can be reported.
- In the event that the patient is unable to give a ROS, the physician must document the reason to receive a complete ROS for coding purposes.

Past, Family, Social History (PFSH)

- Past History
  - Prior major illnesses and injuries
  - Prior operations and/or hospitalizations
  - Current medications
  - Allergies
  - Age appropriate immunizations
  - Diet

Past, Family, Social History (PFSH)

- Family History
  - Health status or cause of death of parents, siblings and children
  - Specific diseases related to problems identified in CC, HPI, and/or ROS
  - Hereditary diseases of family members that may affect patient

Past, Family, Social History (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

Physical Examination

- The extent of the exam is dependent on clinical judgment and the nature of the presenting problem
- There are 4 levels of examination services
  - Problem Focused
  - Expanded Problem Focused
  - Detailed
  - Comprehensive

Physical Examination (PE)

- **Problem Focused**: A limited examination of the body area or organ system
- **Expanded Problem Focused**: A limited examination of the affected body area or organ system and other symptomatic or related body system
- **Detailed**: An extended examination of the affected body area(s) and other symptomatic or related organ system(s).
- **Comprehensive**: A general multisystem examination or a complete examination on an organ system.

Complexity of Medical Decision Making

- Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option.
  - Number of possible diagnoses and/or the number of management options
  - Amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed
  - Risk of significant complications, morbidity, and/or mortality, as well as comorbidities, associated with the patient's presenting problems, diagnostic procedures, and/or possible management options

Medical Decision Making Charts

Number of Diagnoses/Complexity of Data

Self-limited or minor (stable, improved, worsened)—points per Dx	1 point
Established problem (to examining MD); stable or improved	1 point
Established problem (to examining MD); worsening	2 points
New problem (to examining MD); no additional workup planned	3 points
New problem (to examining MD); additional workup	4 points

Lab ordered/reviewed	1 point
X-ray ordered/reviewed	1 point
Medicine section (90701-99199) ordered/reviewed	1 point
Discussion of test results with performing MD	1 point
Obtaining old records/obtaining Hx from someone other than patient	1 point
Review & summary of old records/discussion with other health provider	2 points
Independent visualization of image, tracing, or specimen	2 points

Complexity of Medical Decision Making

Number of Diagnoses or Management Options	Amount and/or Complexity of Data	Risk of Complications and/or Morbidity or Mortality	Type of Decision Making
Minimal	Minimal or None	Minimal	Straightforward
Limited	Limited	Low	Low Complexity
Multiple	Moderate	Moderate	Moderate Complexity
Extensive	Extensive	High	High Complexity

Final Medical Decision Making

E/M Level – 2/3

	Straightforward	Low	Moderate	High
Number of diagnoses/treatment options	1	2	3	4
Amount and/or complexity of data	1	2	3	4
Risk of complications, morbidity, mortality	Minimal	Low	Moderate	High

Initial Inpatient E/M Examples

- 99221
  - Hospital admission, examination, and initiation of treatment program for a 67-year-old male with uncomplicated pneumonia requiring IV antibiotic therapy
- 99222
  - Initial visit for a 61-year-old male with a history of previous MI, who now c/o chest pain
- 99223
  - Initial visit for a 70-year-old male with cutaneous T-cell lymphoma who has developed a fever and lymphadenopathy

Inpatient Hospital Care – Initial Visit – Requires 3/3

E/M Code	99221	99222	99223
HISTORY	Detailed	Comprehensive	Comprehensive
CC	Required	Required	Required
HPI	4+ elements	4+ elements	4+ elements
ROS	2-9 elements	10 elements	10 elements
PFSH	1 PFSH	3 PFSH	3 PFSH
EXAM	Detailed	Comprehensive	Comprehensive
1995 Exam	Detailed 2-7	8+ organ systems	8+ organ systems
MDM	Straightforward	Moderate	High
Problem	Low Severity	Moderate Severity	High Severity

Subsequent Care E/M Examples

- 99231
  - Subsequent hospital care for a 50-year-old male with uncomplicated MI who is clinically stable and without chest pain
- 99232
  - Follow-up visit for a 67-year-old male with CHF who has responded to antibiotics and diuretics, and has now developed a monoarthropathy
- 99233
  - Subsequent visit for a 50-year-old diabetic, hypertensive male with nonresponding back pain and radiating pain to left lower extremity, who developed chest pain, cough, and bloody sputum

Inpatient Hospital Care
Subsequent Care – Requires 2/3

E/M Code	99231	99232	99233
History	Problem Focused	Expanded Problem Focused	Detailed
CC	Required	Required	Required
HPI	1-3 HPI	1-3 HPI	4+HPI
ROS	0	1+ elements	2-9 elements
PFSH	0	0	1 since last visit
Exam	Problem Focused	Expanded Problem Focused	Detailed
1995 Exam	Limited exam problem area	Problem area + one other	Descriptive exam of 1 +
MDM	Low	Moderate	High
Problem	Stable, Improving	Minor Comp, not responding	Major Comp, Unstable

Critical Care Services

- Critical care is delivered directly by an MD to a patient who has a high probability of imminent or life threatening deterioration, which involves high complexity decision making to assess, manipulate, and support vital system functions.
- Critical care codes are based on time spent engaged in work directly related to the patient's care whether that time is spent at the bedside or on the floor or unit.
- **Time Must Be Documented!!!!**

Critical Care Inclusions

- Cardiac output measurements
- Chest x-rays
- Pulse oximetry
- Blood gases, ECGs, blood pressures, hematologic data
- Gastric intubation
- Temporary transcutaneous pacing
- Ventilatory management
- Vascular access procedures

Critical Care

- Critical care & other E/M services may be provided to the same patient on the same DOS by the same physician
- 99291 & 99292 are used to report the total duration of time spent (same principle as Discharge billing)providing critical care services, even if it is not continuous
- If the patient is unresponsive, time spent with family members discussing the patient's management may be reported as critical care

Critical Care - 99291

- 99291
  - Critical care for the E/M of the critically ill or injured patient; first 30-74 minutes (30 minutes-1 hr.-14min.)
  - Should only be used once per date, even if the time reported does not reflect continuous care of up to 74 minutes
- E/Ms lasting less than 30 minutes should be reported with the appropriate E/M code

Critical Care - 99292

- 99292
  - Critical care E/M of the critically ill or injured patient; each additional 30 minutes
  - 74-104 minutes (99291x1 and 99292x1)
  - 105-134 minutes (99291x1 and 99292x2)
  - 135-164 minutes (99291x1 and 99292x3)
  - 165-194 minutes (99291x1 and 99292x4)

Modifier -24

- Modifier -24 is used to indicate that an unrelated evaluation and management service was performed during the post-operative global period.

Modifier-24

- Generally subsequent hospital visits by the surgeon during the same hospitalization as the surgery are considered to be related to the surgery and are therefore not reimbursable; however, if the documentation and the diagnosis code clearly demonstrate that the service is not part of the anticipated post-operative care then it should be billed with the -24 modifier, and paid.

Modifier-24

- Unrelated services include:
  - Visits unrelated to the patient's surgical diagnosis and which the surgeon is treating
  - Treatment for post-operative complications requiring a return to the operating room
  - A more extensive procedure when a less extensive procedure has failed
  - Immunosuppressive therapy
  - Critical care services unrelated to the surgery

Electronic Medical Record Documentation

- Identified Areas of Concern with regard to EHR documentation:
  - Authorship Integrity
  - Documentation Integrity

Integrity Issues

- Authorship Integrity
  - Authorship is the origin of recorded information that is attributed to a specific individual
  - EHRs allow multiple parties to enter information into a service note, the verifying physician who ultimately legalizes a note is responsible for all documentation contained in the note
  - It is important that services be performed and documented in the electronic record by only those individuals who are licensed to perform such services

Integrity Issues

- Automated insertion of clinical data:
  - Use templates with care, auto generated negative findings can lead to an inappropriate clinical picture and call into question the accuracy of the entire note
  - Templates are designed to save time but they can cause problems if they are not reviewed and monitored.

EHR Documentation Tips

- Be mindful of contradictions
- Only document what was done on the date of service
- Do not document a history or exam that is not medically necessary
- The electronic note should be as concise or detailed as the handwritten note…. In other words, just because it is easier to add information using templates and copy/paste does not mean that it supports the service