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.
- 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
“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
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

<table>
<thead>
<tr>
<th>Description</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-limited or minor (stable, improved, worsened)—points per Dx</td>
<td>1 point</td>
</tr>
<tr>
<td>Established problem (to examining MD); stable or improved</td>
<td>1 point</td>
</tr>
<tr>
<td>Established problem (to examining MD); worsening</td>
<td>2 points</td>
</tr>
<tr>
<td>New problem (to examining MD); no additional workup planned</td>
<td>3 points</td>
</tr>
<tr>
<td>New problem (to examining MD); additional workup</td>
<td>4 points</td>
</tr>
<tr>
<td>Lab ordered/reviewed</td>
<td>1 point</td>
</tr>
<tr>
<td>X-ray ordered/reviewed</td>
<td>1 point</td>
</tr>
<tr>
<td>Medicine section (90701-99199) ordered/reviewed</td>
<td>1 point</td>
</tr>
<tr>
<td>Discussion of test results with performing MD</td>
<td>1 point</td>
</tr>
<tr>
<td>Obtaining old records/obtaining Hx from someone other than patient</td>
<td>1 point</td>
</tr>
<tr>
<td>Review &amp; summary of old records/discussion with other health provider</td>
<td>2 points</td>
</tr>
<tr>
<td>Independent visualization of image, tracing, or specimen</td>
<td>2 points</td>
</tr>
</tbody>
</table>
## Complexity of Medical Decision Making

<table>
<thead>
<tr>
<th>Number of Diagnoses or Management Options</th>
<th>Amount and/or Complexity of Data</th>
<th>Risk of Complications and/or Morbidity or Mortality</th>
<th>Type of Decision Making</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>Minimal or None</td>
<td>Minimal</td>
<td>Straightforward</td>
</tr>
<tr>
<td>Limited</td>
<td>Limited</td>
<td>Low</td>
<td>Low Complexity</td>
</tr>
<tr>
<td>Multiple</td>
<td>Moderate</td>
<td>Moderate</td>
<td>Moderate Complexity</td>
</tr>
<tr>
<td>Extensive</td>
<td>Extensive</td>
<td>High</td>
<td>High Complexity</td>
</tr>
</tbody>
</table>
## Final Medical Decision Making
### E/M Level – 2/3

<table>
<thead>
<tr>
<th></th>
<th>Straightforward</th>
<th>Low</th>
<th>Moderate</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of diagnoses/treatment options</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Amount and/or complexity of data</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Risk of complications, morbidity, mortality</td>
<td>Minimal</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
</tr>
</tbody>
</table>

- **Straightforward**
- **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

<table>
<thead>
<tr>
<th>E/M Code</th>
<th>992221</th>
<th>99222</th>
<th>992223</th>
</tr>
</thead>
<tbody>
<tr>
<td>HISTORY</td>
<td>Detailed</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
</tr>
<tr>
<td>CC</td>
<td>Required</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>HPI</td>
<td>4+ elements</td>
<td>4+ elements</td>
<td>4+ elements</td>
</tr>
<tr>
<td>ROS</td>
<td>2-9 elements</td>
<td>10 elements</td>
<td>10 elements</td>
</tr>
<tr>
<td>PFSH</td>
<td>1 PFSH</td>
<td>3 PFSH</td>
<td>3 PFSH</td>
</tr>
<tr>
<td>EXAM</td>
<td>Detailed</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
</tr>
<tr>
<td>1995 Exam</td>
<td>Detailed 2-7</td>
<td>8+ organ systems</td>
<td>8+ organ systems</td>
</tr>
<tr>
<td>MDM</td>
<td>Straightforward</td>
<td>Moderate</td>
<td>High</td>
</tr>
<tr>
<td>Problem</td>
<td>Low Severity</td>
<td>Moderate Severity</td>
<td>High Severity</td>
</tr>
</tbody>
</table>
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

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