Test Your Coding Skills

Go head to head with our review panel in coding six troublesome progress notes.

Olivia K. Maresh

Think about the coding and documentation problems you've run into in your practice. Do you undercode some visits? Do insurers frequently downcode or reject your claims? Are you sometimes stumped or puzzled when it comes time to code a service you've provided? Studies suggest that coding inaccuracy and confusion are everyday occurrences in many family practices. Consider the following:

• A study published in the May/June 2001 issue of the *Journal of the American Board of Family Practice* found that family physicians overcoded new patient evaluation and management (E/M) visits 82 percent of the time and undercoded established patient E/M visits 33 percent of the time.[1]

• The Direct Observation of Primary Care Study found that family physicians either overcoded or undercoded 45 percent of visits.[2] The authors of the study determined that "family physicians tend to undervalue the time they spend in longer visits that have less focus on treatment … [and] tend to overcode for visits that are focused on prevention or treatment, more social, less complicated or shorter."[3]

Family physicians' problems with coding could be traced to any number of causes, such as the complexity of the codes themselves, limited coding training and inadequate documentation. In any case, it's an area of practice management that could be improved in many practices. This article will enable you to test your own procedural coding and documentation skills.

The following six progress notes were submitted by family physicians who identified these visits as especially difficult to code. Patient names have been removed and a few minor formatting changes have been made; otherwise, these are the actual notes. Read carefully through each one and then fill in the blank following each note with the procedure code or combination of codes you

Olivia Maresh is an associate editor for Family Practice Management. *Conflicts of interest: none reported.*

CME

THE REVIEWERS

The coding recommendations presented in this article were given by a panel of family physicians, consultants and certified professional coders. The reviewers were asked to read each progress note and submit recommendations, which were then combined into the responses that appear in the article. The following people participated in the panel: Robert H. Bosl, MD, FAAFP, Starbuck Clinic, Starbuck, Minn.; Thomas A. Felger, MD, ABFP, CMCM, St. Joseph Regional Medical Center, South Bend, Ind.; David Filipi, MD, MBA, and the Coding and Compliance Department of Physicians Clinic, Omaha, Neb.; Emily Hill, PA-C, Hill & Associates, Wilmington, N.C.; and Joy Newby, LPN, CPC, Joy Newby & Associates Inc., Indianapolis, Ind.

ILLUSTRATION BY CHRIS LENSCH

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would submit. After you have coded each note, compare your selections to those recommended by our reviewers in the next section of the article.

Progress note 1

Established patient office visit, annual exam and skin-tag removal, chronic condition.

S: Pt here for Pap – taking B/C daily. Pt c/o spotting throughout the month. Pt here for gyn exam and excision of skin tags. On Estrostep x two yrs, but for past 6 mo has had heavy periods and bleeding midcycle. No cramps/dysmenorrhea. No other complaints. Monogamous – husband having vasectomy this week. Multiple skin tags on neck, axilla and breasts which have become irritated and painful. Atenolol has improved palpitations but not headaches. Husband feels she is much more cranky, irritable off Paxil than she had been on it. Pt has appt with therapist next wk and will restart Paxil. H/O abnml Pap 8 yrs ago – now all WNL.

O: B/P: 110/90, Temp: 98.5. Comf, NAD. Breasts: no masses, no LAD. CV RRR, no m. Vulva/vagina WNL. Cervix WNL, no CMT. Uterus 6 w size. Adnexal: no masses. Multiple skin tags.

A/P: 1. Gyn exam: prob fibroids. Pap done. Cont OCPs x 6 wks, then d/c. If menses very heavy, will do ultrasound to r/o fibroid.
2. Anxiety: Paxil 10 mg Qd x 7d, then 20 mg Qd. Encouraged therapy.
3. Skin tags. Verbal consent obtained. Areas cleaned with Betadine and cut off, min bleeding, Band-Aids applied, wound care rvwd.

How would you code progress note 1?

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Progress note 2

Established patient office visit, cold symptoms, tobacco user.

S: CC: Sick x 1 wk.
HPI: 25 yo M c/o runny nose, congestion, ST, cough. Not improving with tyl cold and flu. Wants Abx. Son has sim sx at home. Onset one wk ago. Cough is nonproductive. Sx mildly affecting sleep. #1 Sx: congestion.
ROS: No recent F/C. No N/V/D.
Soc: +Tob, occ EtOH. Of note, is willing to quit Tob within the next month. Has been considering for some time. Tried once prior last yr but relapsed.

O: Temp: 97.9, Pulse: 84, Resp: 16, BP: 136/78. NAD, TMs: shiny grey + landmarks, NP: no d/c. OP: pink, some cobblestones, no exud. Neck: no LAN. Lungs: CTA bilat, CV: RR no M.

A/P: 1. URI: nl course. Pt educ and reassurance. Verbal underst. Rx: Deconamine SR bid prn #14/0, f/u if sx worsen or persist in 7-10 days.
2. Tob Abuse: preparation stage.
3. Tob Counsel: d/w pt benefits of cess, stress vs habit cigs and techniques to quit. C/S local cess class.

How would you code progress note 2?

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Progress note 3

Established patient office visit, hernia, chronic conditions.

S: CC: Talk to doctor. Patient is a 54-year-old recovering alcoholic who I've been seeing for several years. He's never been very open about his personal situation, has declined any professional help. Apparently things have gotten bad for him, and he told me quickly last visit that he was going to talk to me next time. Gave me a long letter he had written to prepare me for this visit. The letter talks about how he can't hold things together any longer, can't go on working. At the age of 13, he says he went through a "personality change" where he had to be very rigid with certain behaviors. He's like that even more now, can't fit this into the workday. He gave me lots of examples of this in his letter. He feels very depressed, feels paranoid about other people, has to keep the same routine going. Apparently someone else at work had a similar set of problems and now is receiving disability. Patient wonders if that would work for him. I've tried him on antidepressants before, and he didn't buy into it, didn't stick with them for very long. He's also been in substance-abuse therapy, didn't connect with any counselor for very long. Apparently, he went to an ER about a month ago because he felt a lump in his right groin. They told him he had a hernia and to tell me about it. He thinks that's been present for about two months. He's had some urinary incontinence, says he's better on Ditropan XL 5 mg Q day. His medical health has been good, and he really hasn't shown any physical complications of alcoholism. He's been sober by his description for a few years now. I believe him, because when he's drinking he ends up in ERs and other places that come to my attention.

O: BP: 120/78, Wt: 136 lbs. Heart: Regular without murmur. Lungs: Clear. Abdomen shows a soft, reducible right inguinal hernia.

A: 1. Major depression.
2. Alcoholism, in recovery.
3. Urinary incontinence.
4. Rt inguinal hernia.

P: 1. Because of the issues raised in the letter, I referred him to a psychiatrist.
2. We talked about the inguinal hernia. He's going on vacation in a few weeks, isn't having any pain, so wants to wait until after vacation to see a surgeon.
3. Ditropan XL 5 mg one Q day #30 refill x two.
4. He will see me in two months.

5. I gave him back his letter to take to the psychiatrist, since he is much more expressive in writing than speaking. I kept a copy for the chart.
6. This note is to serve as a letter of introduction to his psychiatrist.

How would you code progress note 3?

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Progress note 4

Established patient office visit, annual exam, chronic conditions.

S: CC: 65-year-old female presents for yearly well-woman exam. Post menopausal. Needs refills on medications. Last mammogram was 2 yrs ago.
HPI: Markedly runny nose when eating … for months to years. Is here for routine periodic health screening and examination. Her last physical exam was 1 yr ago. She is menopausal. She performs breast self-exams occasionally. Her last mammogram was 2 yrs ago. Denies any history of abnormal Pap smears. Lots of stress bladder incontinence.
Current medications: Atrovent 0.03% nasal spray, 2 sprays each nostril tid prn runny nose; Provera 2.5 mg tablets, 1 tablet po qd for progesterone; Zoloft 100 mg tablets, 1/2 tablet po qd; Estrace 1 mg tablets, 1 tablet po qd; Elavil 100 mg tablets, 1 tablet po hs.

O: Vitals: Wt: 116.5 lb, Ht: 60", BMI: 22.75, BP: 126/78, left arm sitting. Exams: General: well developed, well nourished, well groomed; no apparent distress. Neck: range of motion is normal; thyroid exam reveals no thyromegaly. Cardiovascular: normal rate; rhythm is regular; normal S1 and S2 with no S3/S4 gallop, rubs or clicks; no systolic murmur; no diastolic murmur. Gastrointestinal: nontender; normal bowel sounds; no organomegaly; no masses. Genitourinary: Pap smear taken; rectal confirmatory of pelvic findings. External genitalia: normal without lesions or urethral abnormalities. Vagina: normal with good pelvic support and no lesions or discharge. Cervix: smooth and unremarkable noted. Uterus: small, smooth and unremarkable. Adnexa: no palpable masses and no unusual tenderness. Breast/integument: Skin: no significant rashes or lesions; no atypical or suspicious moles. Breast exam: no overlying skin changes; no breast masses. Psychiatric: appropriate affect and demeanor; normal thought and perception.

A: 472.0 Chronic rhinitis.
V72.3 Well-woman exam.
625.6 Stress incontinence.
784.0 Headache.
300.02 Anxiety.

P: 1. Chronic rhinitis: Atrovent 0.03% nasal spray, 2 sprays each nostril tid prn runny nose; dispense one 30 mL bottle (345 sprays), 12 refills.
2. Well-woman exam: estradiol 1 mg tablets, 1 tablet po qd for estrogen; dispense 90 tablets, 3 refills. Provera 2.5 mg tablets, 1 tablet po qd for progesterone; dispense 90 tablets, 3 refills.
3. Stress incontinence.
4. Headache: amitriptyline HCl 10 mg tablets, 1 tablet po q prn; dispense 90 tablets, 3 refills.
5. Anxiety: Zoloft 100 mg tablets, 1 tablet po qd; dispense 90 tablets, 3 refills.

How would you code progress note 4?

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Progress note 5

New patient office visit, chest pain.

S: CC: New pt. Chest pain.
HPI: 49 yo female changing insurance, here for H/P. C/o pain along rib cage anteriorly for past one month. Tender to touch. Pt also has not had mammogram in > 1 yr. Tobacco abuse.
ROS: Constitutional: nl. Skin: 3 mo; skin rashes; dust mite allergies; oral steroids. Eyes: glasses 5/01 exam. ENT: slight sinus drainage. CV: palpitations, no racing. Resp: No SOB; no cough. Breast: occasion. GI: nausea, heartburn occ for 1 month at time. GU: no UTI. Hem/Lymph: nl. Endo: nl. Neuro: occ. HA sinus. Psych: no depression; no anxiety. MS: nl. Allgy/Immun: dust/mites, trees, grass, smoke. Paps: normal. Cycles: abnormal; began at 38.
Habits: Smoking: 1 ppd x 20 yrs. Alcohol: none. Drugs: none. Seat belts: always.
Past History: Surgical: hysterectomy with bladder repair 6 yrs ago, T/A, cholecystectomy, appendectomy, D/C, cyst removed (vaginal?). Medical: none, Hep B? Psychiatric: none. Obstetrical: G3P3 – C-sections x 3.
Family History: F: 77, stroke, asthma. M: Alzheimer's, 83 yo. Brs: 2 – tobacco, TB, bronchiectasis, both have lobectomies, good health. Sis: 1 – diet controlled DH, heart problems, stents. Kids: 3: 29 – son, asthma; 24 – son; 22 – son.
Social History: Living arrangements: husband + 1 stepson. Education: some college.

O: Wt: 129, BP: 116/74, P: 64, R: 16, Age: 49, private insurance. Medications: none. Allergies: Demerol, Vistaril, codeine.
Constitutional: nl. Skin: no rashes; no moles. Eyes: PERRLA EOM I. ENT: no ear/nasal d/c; no oropharynx exudates/erythema. Neck: supple carotid pulses 2t; no bruits; no JVD. Resp: CTA exp wheeze occasional. CV: RRK no RMG. Breasts: no masses, lumps; no nipple d/c. GI: S/NT/ND/+BS well-healed cholecystectomy/C-section. GU: no Pap smear. Lymphatic: no cervical; no axillary; no inguinal LAD. Neuro: strength 5/5 sensation – I. Psych: no depression; good affect; good sleep patterns; slight anxiety

per pt stressful lifestyle. MS: good ROM tenderness over anterior costophrenic/sternum.

A: Anxiety. Tobacco abuse. Chest pain.

P: Cholesterol.
Mammogram.
Hepatitis/LFT.
CXR.
Zyban.
Ibuprofen.

How would you code progress note 5?

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Progress note 6

Established patient office visit, annual exam.

S: CC/HPI: 41 yo female. Pap, no complaints. No abdominal pain; may have some vaginal discharge. States that she is feeling good and no major complaints. Sinus discharge. Pt expectations: prevent CA. ROS: Const: normal. CV: no chest pain. ENT: sinus OK. GI: OK. Mus/Ske: OK. Resp: no SOB.

O: Vital signs: B/P: 120/80, Pulse: 78, Resp: 16, Temp: 97.5, Ht: 5-1, Wt: 101. Physical exam, document findings: Constitutional: nor, NAD. Cardiovascular: nor, regular. Respiratory: nor, rhonchi and crepitant (smoker). GI & Abdomen: nor; supple; no mass; peristalsis is normal. Genitourinary: abn; vulva nor; vagina nor; some whitish discharge. No cervix (pt had hysterectomy); vaginal touch nor. Breast R/L: abn; over: no suspicious mass; arm pit nor; nor breast exam. Skin: nor.

A: Vaginitis (yeast).

P: Diflucan 150 mg tablet; pt has some at home.
Mammogram – wants to wait.
Pap test done.
Vaginal culture done.
D/C cigarettes.
Referral & consult: no. Med Rec Req: no. Follow up: 6 weeks or PRN.

How would you code progress note 6?

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Coding recommendations

Each of our five coding reviewers suggested how best to assign procedure codes to the visits described in the progress notes you just read. In some cases, the reviewers recommended a particular code or combination of codes based on the documentation in the progress note but also explained how another code might have been appropriate if the documentation had been more complete. You'll also see that in some cases even the review panel was unable to come to an agreement on which codes were most appropriate. In such cases, we present all points of view and leave it to you to decide which approach you'd be most comfortable taking. (For more information about the coding review panel, see the box on page 41.)

Progress note 1

Reviewers' recommendations: 9939x-25 + 11200 or 99213-25 + 11200 or 99214-25 + 11200

For this visit, three reviewers recommended one of the preventive medicine services codes 99391-99397 (determined by the patient's age, which is not included in this note), 11200 for the removal of the skin tags, and modifier -25 attached to the preventive medicine services code since the procedure was performed on the same day as a significant, separately identifiable E/M service. According to one of the reviewers, "the documentation in this note does not clearly support a service above that included in the preventive service."

However, two reviewers coded this as a problem-oriented visit. One recommended 99213-25, pointing out that the review of systems (ROS) and exam documentation do not cover the range you'd expect for a preventive medicine visit. The other reviewer cited the detailed history, detailed exam and moderate complexity decision making of the visit for the selection of 99214-25.

In all cases, the reviewers commented that the note should have included the number of skin tags removed. The first 15 lesions removed are included in 11200, but for each additional 10 lesions removed, code 11201 can be added.

Progress note 2

Reviewers' recommendation: 99213

Four of our reviewers agreed that the documentation of the history and exam in this note could support 99214. However, several indicated that the nature of the presenting problem and the questionable medical necessity of parts of the exam would make 99214 hard to defend, so they opted for 99213 instead. The fifth reviewer indicated that the history and decision making supported 99213 and no higher.

Progress note 3

Reviewers' recommendations: 99213 or 99214

Three reviewers agreed that the documentation in this note easily supports 99213 when the guidelines for history, exam and decision making are applied. Two said the note supports 99214. One reviewer pointed out that the decision whether to code 99213 or 99214 may boil down to how the genitourinary and psychiatric reviews are counted. Also, four of the reviewers noted that if the physician had spent a significant amount of time providing counseling to the patient (more than half of a visit that lasted 25 to 39 minutes) and such encounter time had been documented, 99214 would have been the appropriate code. Code 99213 is associated with 15 to 24 minutes, and 99215 with 40+ minutes.

Progress note 4

Reviewers' recommendations: 99397 + Q0091 + G0101 or 99214 + Q0091 + G0101

Three reviewers coded this as an annual well-woman exam for a Medicare patient, using preventive medicine services code 99397 and HCPCS codes Q0091 (for the collection

of the Pap smear) and G0101 (for the clinical breast/pelvic exam). All three indicated that while they had considered the possibility of submitting a problem-oriented visit code to account for the work associated with treating the patient's chronic problems, they didn't believe the note adequately supported that strategy. Several chronic conditions are addressed in the assessment and plan portions of the note but are given too little attention in the history and exam documentation to justify using a problem-oriented E/M code, they said. For example, one reviewer pointed out that headache is not mentioned in the history and there is no documentation of a neuro or HEENT exam. Similarly, rhinitis, although addressed in the history of present illness, is not addressed in the exam.

Two reviewers selected 99214 rather than the preventive medicine services code. One characterized this as a "well-documented, well-woman encounter with management of several chronic conditions." The other cited evidence of a detailed history, detailed exam and moderate complexity decision making and pointed out that the visit focused more on disease-related problems (stress incontinence, chronic rhinitis, etc.) than on preventive care (e.g., no cancer screening or cholesterol screening were done).

Progress note 5

Reviewers' recommendations: 99386 or 99386 + 99201-25 or 99204

Three reviewers agreed that the primary focus of this note is on preventive services, and they coded the visit accordingly as a 99386. All three felt that clearer and more thorough documentation of the problem-oriented portion of the visit would have helped make a better case for also submitting a problem-oriented code. For example, one reviewer said the physician should have documented his or her assessment of the chest pain and why the tests were ordered. Two of the three reviewers decided the documentation was sufficient to justify submitting 99201 (with modifier -25 attached to indicate this was a significant, separately identifiable service) in addition to the preventive medicine services code.

The other two reviewers saw evidence in the note of a comprehensive history, comprehensive exam and decision making of moderate complexity, and they coded the visit as a 99204. One reviewer pointed out that, although some screening was done, the patient's presenting complaint of chest pain makes this a problem-oriented visit.

Progress note 6

Reviewers' recommendation: 99396

Most of the work of this visit is associated with preventive services, and the consensus among our reviewers was that it should be coded accordingly with 99396. One reviewer said that submitting a problem-oriented E/M code would help to account for the additional work associated with diagnosing and treating the patient's vaginal infection, but it is difficult to justify billing an additional E/M service for a problem such as vaginitis since the necessary exam is included in a typical well-woman exam. In the words of another reviewer, the vaginal infection was an "incidental finding and did not change the overall focus of the encounter from preventive care."

Since the reviewers could agree on only two notes, it's reasonable to argue that there's no correct answer to some of these questions.

How did you do?

Since the reviewers could agree on procedure codes for only two of the six notes, it's reasonable to argue that there's no correct answer to some of these coding questions – or, more cynically, that the "correct" answer is up to your insurer. The reason may be inadequacies of documentation or some fundamental mismatch between the E/M documentation guidelines and the reality of practice. Whatever the cause, where our reviewers disagreed, the majority took the more conservative course.

If your coding choices followed those of at least some of our reviewers, you probably have a good grasp of E/M coding. On the other hand, if your coding choices weren't even close to the reviewers' recommendations, you might want to consult some resources for improving your coding and documentation skills. (For a list of resources available from *FPM,* visit this article online at www.aafp.org/fpm/20020200/41test.html.) Either way, perhaps this glimpse into the way your progress notes are turned into reimbursable codes can help you as you document and code your next patient visit. FM

Editor's note: We cannot guarantee that third-party payers will accept the coding and documentation recommended in this article. Because CPT and ICD-9 codes change annually, you should refer to the current CPT and ICD-9 manuals and the "Documentation Guidelines for Evaluation and Management Services" for the most detailed and up-to-date information.

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