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2 Tried-and-True Tools for E/M Documentation

They don't just help you code better. They also help make the documentation guidelines less annoying.

Leigh Ann Backer

As you know only too well, the Medicare *Documentation Guidelines for Evaluation and Management Services* are part of the fabric of practice today. It is a mark of how crazy the health care system is that you can choose between two sets of guidelines – one published in 1995 that was theoretically superseded and one published in 1997 that was never fully imposed. Still, this is where we are and where we're likely to be for a while (see "An Update on the E/M Codes and Documentation Guidelines," *FPM,* May 2003, page 14).

ILLUSTRATION BY SUZETTER BARBIER

Most family physicians apparently choose to follow the 1997 guidelines despite their greater complexity, probably because of their reduced ambiguity. With that in mind, we have decided to republish the most popular coding tool ever to appear in *FPM,* the *FPM* Pocket Guide to the Documentation Guidelines, in the 1997 version (see "Three Documentation Tools That Work," *FPM,* January 1998, page 29). Despite its having been distributed free of charge in over 100,000 copies of *FPM,* this version of the pocket guide has sold thousands and thousands of copies through the AAFP Order Department. If your copy is getting dog-eared, here's a chance for a fresh one, and if you have somehow missed it, here's your chance to try it out.

We have decided to republish the most popular coding tool ever to appear in *FPM,* the *FPM* Pocket Guide to the Documentation Guidelines.

As a companion to the pocket guide, we're also including a progress note form that's designed to make it as easy as possible for you to document the way you need to for clinical purposes

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***FPM* is republishing tools designed for the 1997 E/M documentation guidelines, which seem to be the ones adopted by most family physicians.**

A progress note form that includes checklists of systems and body areas can help to relieve at least some of the exam documentation burden.

Negative responses on the ROS and negative findings on the exam that are relevant to the presenting problem must be documented.

while still producing a note that's easy to "score" using the documentation guidelines – and the pocket guide.

The progress note form

The salient feature of the progress note is a checklist designed to make it easier to count systems and body areas (see page 53). That stands to reason, since one of the major burdens imposed by the 1997 guidelines is the necessity of doing that counting. To count clinical elements for the exam (referred to as "bulleted elements" in the guidelines), you'll still have to work through your note, but the checklist gives you a head start.

To use the checklist, put a check mark in the appropriate column for every system you cover in the ROS, every area of the PFSH you touch on and every system or body area you examine. In circumstances where you would normally write, for example, "GI normal" with no further elaboration, a check mark in the "WNL" column should suffice. Since the guidelines require that you note explicitly any negative responses on the ROS and negative findings on the exam that are relevant to the presenting problem, the other column of check boxes is headed "See note" rather than, say, "Abnormal."

You should be able to quickly determine the number of systems covered in the ROS and the number of areas covered in the PFSH by counting the check marks in those sections of the form. Before you can determine the level of history, you'll also need to count the elements of the HPI that appear in the note. The elements of the HPI are listed on the form to help you remember what to look for.

To determine the level of exam, you'll be able to count the number of systems and body areas by counting check marks. Then you'll need to compare your note with the appropriate list of bulleted elements from the 1997 guidelines. (The pocket guide discussed below includes a version of the list for the general multisystem exam, making it a good companion to the progress note form.)

The form provides no checklist for documenting medical decision making; to assess that, you'll need to refer to your note. It does, however, provide a shortcut for documenting encounters dominated by counseling or coordination of care. Simply check the box labeled "Couns/coord > 50%" (i.e., "Counseling and/or coordination of care took more than 50 percent of the visit"), enter the total time (face-to-face or floor time, as appropriate) of the encounter and the time devoted to counseling and/or coordination of care, and describe in the note the counseling and/or activities to coordinate care that you provided.

KEY POINTS

- Most family physicians seem to prefer the 1997 E/M documentation guidelines despite their complexity.
- A chart note form designed with the guidelines in mind can make documentation easier.
- The *FPM* Pocket Guide is a convenient reminder of the major points involved in generating the proper E/M code for a visit.

The pocket guide

The *FPM* Pocket Guide to the Documentation Guidelines is printed on heavy stock for durability. You'll find it facing page 77. When the guide is properly cut out and folded, the headings Exam and Decision Making should be showing above the History table as in the illustration on the guide. The gray arrow in the History table indicates that the History table contributes information to the History column of the two code selection tables at the top. Open the first flap and on the right you should see an Exam table with a gray arrow indicating its relationship to the Exam column of the Code Selection tables. Lift up the small flap carrying the exam table and you should see a two-column table that lists the clinical content of the comprehensive general multisystem exam as it's defined in the new documentation guidelines. (We chose to include the general multisystem exam because of its prevalence in family medicine.) Close the small flap, open the third flap, and you should see three tables that contribute information to the Decision Making table and a gray arrow indicating

The pocket guide is designed to jog your memory, not to teach you everything you need to know about the guidelines.

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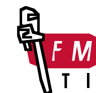
PROGRESS NOTE



Name: ______________________________ Date: ______________________

DOB: ____________________ H: ______ W: ______ T: ______ P: ______ BP: ______ R: ______

HPI

Location, quality, severity, duration, timing, context, modifying factors, associated signs and symptoms.

ROS	WNL	See note
Const	❏	❏
Eyes	❏	❏
ENT/mouth	❏	❏
CV	❏	❏
Resp	❏	❏
GI	❏	❏
GU	❏	❏
Musc	❏	❏
Skin/breasts	❏	❏
Neuro	❏	❏
Psych	❏	❏
Endo	❏	❏
Hem/lymph	❏	❏
Allerg/immun	❏	❏
PFSH	**No chng**	**See note**
Past	❏	❏
Family	❏	❏
Social	❏	❏
Exam	**WNL**	**See note**
Const	❏	❏
Eyes	❏	❏
ENT/mouth	❏	❏
Neck	❏	❏
Resp	❏	❏
CV	❏	❏
Chest (breasts)	❏	❏
GI (abdomen)	❏	❏
Lymph	❏	❏
GU	❏	❏
Musc	❏	❏
Skin	❏	❏
Neuro	❏	❏
Psych	❏	❏

No ✔: no review/exam

Nurse's Note: ____

____

CC:

HPI:

Couns/coord > 50% ❏

Total time: _________ min.

Physician's Signature: ______________________________ Couns/coord time: _________ min.

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"Two Tried-and-True Tools for E/M Documentation." Backer LA. *Family Practice Management.* October 2003:51-55, http://www.aafp.org/fpm/20030900/51twot.html.

FAMILY PRACTICE MANAGEMENT®

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The *FPM* Pocket Guide is a useful memory aid, not a substitute for thorough reading and assimilation of the guidelines.

Once you understand the guidelines, the pocket guide can help you work from your note to the appropriate code.

The pocket guide is also useful as a self-audit tool and a way of fine tuning your seat-of-the-pants coding.

the relationship of decision making to the Code Selection tables.

Keep in mind that the pocket guide is designed to jog your memory, not to teach you everything you need to know about the guidelines. To consult the unabridged version of the tables or the requirements for single-system exams, you'll need to refer to the guidelines themselves. If you don't have them handy in a CPT manual, you can download them from the Centers for Medicare and Medicaid (CMS) Web site at http://cms.hhs.gov/medlearn/master1.pdf.

While the checklist form described earlier is designed to help you as you write or dictate your note, the pocket guide is intended to help you determine the appropriate code, based on what you have documented in the note. You might want to consult the pocket guide before coding a visit, but you'll probably find it more useful as a way of fine-tuning your seat-of-the-pants coding. If you use it to help you in a self-audit from time to time, checking the codes you've submitted for selected visits, you can identify areas where you may be coding too high or too low.

The salient feature of the progress note is a checklist designed to make it easier to count systems and body areas.

Let's use the pocket guide to evaluate the following sample note, which represents a common type of Medicare visit – the routine follow-up visit for a patient with multiple chronic problems and no new complaints:

S: Mr. Doe returns today for a routine four-month F/U for evaluation and management of his NIDDM, hypertension and OA. No new complaints. He denies headache, visual changes, chest pain, SOB or extremity numbness. No increased joint pain. Dietary compliance good, and his BP and home glucose monitoring records indicate acceptable control of both.

O: CONST: BP 138/84, Wt 175, P 82 and regular.
HEENT: PERRLA, EOMI; EACs and TMs nl; oropharynx benign.
NECK: supple w/o JVD, bruits or thyromegaly.
RESP: bs clr to P and A w/o retractions or rubs.
HEART: WNL w/o gallop, murmur, rub, click or irregularity.
EXT: distal pulses intact w/o cyanosis, clubbing or edema.
NEURO: deep tendon reflexes WNL and symmetric; no decreased lower extremity sensation noted.
LABS: FBS 132, UA WNL.

A: 1. Stable NIDDM.
2. Stable hypertension.
3. Stable osteoarthritis.

P: 1. Glucotrol 5 mg daily q.a.m.
2. Procardia XL 30 mg daily.
3. Relafen 1,000 mg daily.
4. Continue home glucose monitoring.
5. SMA-7 and glycosylated hemoglobin today.
6. RTC for routine F/U in 4 months.

Before we go on, you might want to reread the note and decide how to code it without consulting the pocket guide or the guidelines, then read on to compare your analysis with ours.

History. The History table on the front of the pocket guide doesn't include a column for chief complaint, since that is required for all levels of history and not likely to be missing from any progress note. Even though the patient in our example has no new complaints, there is a chief complaint in the first sentence of the note. The guidelines define chief complaint very broadly as a statement "describing the symptom, problem, condition, diagnosis, *physician-recommended return* or other factor that is the reason for the encounter" (emphasis added).

Because the patient is returning for a rou-

A NOTE TO WEB USERS

The pocket guide referred to in this article is not available on the Web due to its format. Copies of the pocket guide are available for purchase (both alone and as part of a collection of tools from the *FPM* Toolbox) through the AAFP Order Department at 800-944-0000 or online at http://www.aafp.org/catalog. (From the online catalog home page, search for item 557 or, for the collection of tools, search for item 511.) A version of the pocket guide based on the 1995 guidelines is also available for purchase as item 556.

The progress note form may be downloaded as a PDF file via a link in the online version of this article. To access the PDF file, you will need Adobe Acrobat Reader, which you may download free of charge.

tine evaluation of three chronic diseases – diabetes, hypertension and osteoarthritis – the HPI is extended.

The ROS includes questions about at least six systems and body areas: eyes, cardiovascular, respiratory, musculoskeletal, neurologic and endocrine. The History table of the pocket guide, then, tells us that the ROS is detailed.

Because the note doesn't really touch on past, family or social history, there is no PFSH. As the History table indicates, expanded problem focused is the highest level possible without a PFSH. Note that simply reviewing the patient's medication list and documenting that fact in the note would have counted as past history, therefore raising the PFSH to detailed and, therefore, the overall level of history to detailed.

Exam. Opening the first flap of the pocket guide exposes on the right the table devoted to the exam, and on the back of the small flap is the table that lists the clinical content of the comprehensive general multisystem exam. The sample note documents findings for eight systems and body areas, which, as the table indicates, meets the requirement for a detailed exam, provided that at least 12 bulleted elements are documented in the note – and, in fact, the note documents 15:

- Constitutional (1 bullet): Any three of seven vital signs;
- Eyes (1 bullet): Examination of pupils and irises;
- ENT/mouth (2 bullets): Examination of oropharynx and otoscopic examination of external auditory canals and tympanic membranes;
- Neck (2 bullets): Examination of neck and examination of thyroid;
- Respiratory (3 bullets): Assessment of respiratory effort, auscultation of lungs and percussion of chest;
- Cardiovascular (3 bullets): Auscultation of heart with notation of abnormal sounds and murmurs, examination of pedal pulses, and examination of extremities for edema and/or varicosities;
- Musculoskeletal (1 bullet): Inspection and/or palpation of digits and nails;
- Neurologic (2 bullets): Examination of deep tendon reflexes with notation of pathological reflexes and examination of sensation.

Medical decision making. Because this is an established-patient visit where the history and the exam differ in level, the level of medical decision making will determine the level of the visit. (As the Code Selection tables indicate, the level of an established-patient visit is determined by the highest two of the three components.) Open the pocket guide fully, and we'll use the decision making tables to evaluate the note.

First, the score for number of diagnoses and management options involved works out to be 3: No new problems are reported, and each established, previously diagnosed problem (diabetes, hypertension and osteoarthritis) counts for one point because they're all stable. Second, in evaluating the amount and complexity of data to be reviewed, we have only lab tests to consider. That gives a score of 1 (the guidelines say no matter how many tests of a given class are requested or reviewed, the note earns no more than one point per class). Finally, the level of risk seems to be moderate, both because the visit involves prescription drug therapy and because it concerns three stable chronic illnesses. Since the level of decision making is determined by the highest two of the three components, the level for this encounter is moderate complexity.

The time you invest in learning better E/M coding can pay off in real money.

To review, then, we have an expanded problem-focused history, a detailed exam and moderately complex decision making to evaluate on the Code Selection table at the top of the pocket guide. Because two of the three are enough to determine the level for an established-patient visit, we end up with a code of 99214 on the strength of the exam and decision making.

Good luck

Despite their complexity, the documentation guidelines can be a useful tool for evaluating your documentation. If you're thinking, "Why bother?" keep in mind that you may have a tendency to undercode to avoid charges of fraud and abuse. The guidelines – and the tools in this article – can help keep you coding at the levels you deserve. The time you invest in learning better E/M coding can pay off in real money. FM

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Use the table of exam requirements on the pocket guide to count the systems and bulleted elements covered in your note.

The guide includes three tables for use in determining the level of decision making – tables of diagnosis and management options, amount and complexity of data, and risk.

Individual "scores" for history, exam and decision making can be translated into an office visit code using the tables at the top of the guide.