

Do You Know What Is (or Isn't) in Your Documentation?



Leaving out key information in patient documentation can compromise quality and cost you money.

As you write your progress notes, you probably cannot help thinking of the many audiences you're serving: yourself, other physicians who may need to consult your notes, the coder and biller who will turn your documentation into claims, and even the auditor or, worse, the plaintiff's attorney. The last two are just shadowy possibilities, and you already know what you and other physicians are likely to need from your notes. But how good are you at producing documentation that coders need for optimal code selection? As a certified professional coder, I'd like to give you a chance to find out.

How would you code the following notes?

First, review and code each of the following notes abstracted from physician documentation. Later in the article, you'll have

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a chance to compare your coding with what a coder or auditor would have assigned based on the 1995 and 1997 Documentation Guidelines for Evaluation and Management Services from the Centers for Medicare & Medicaid Services.

Note 1

CC: Patient One, DOB 6/12/1990, presents with a complaint of a headache for about a week. She denies a history of migraines; however, her mother has frequent problems with them. She has felt quite stressed because of her upcoming wedding. The back of her neck seems sore. She feels her shoulders are tight. She has not been to yoga lately.

Patient is 23 years old and appears stated age. Weight is 132, temp 97.3, blood pressure 118/68. TMs are negative. Throat negative and neck without adenopathy. Lungs are clear. There is a considerable amount of tenderness in the paracervical musculature.

Reassured her this is a muscle tension headache. I have prescribed tramadol and Flexeril for discomfort and told her to follow up with me as needed.

Note 2

CC: Patient Two, DOB 8/26/2006, is a new patient. She complains of vague symptoms of nausea and headaches and wishes to establish care. She has had some mild nausea and frontal headaches occasionally for the past three months. The family has recently moved to Kansas from Iowa. Patient recently had a well-child checkup a few months before moving. A complete family history was obtained – of note, patient's father, maternal GM, and paternal GF have diabetes mellitus.

Physical Exam: General: Pleasant child in NAD, responds appropriately, good eye contact. HEENT: Extraocular movements are intact. Pupils are reactive and symmetric. TMs are normal. Nose/throat clear. Neck: Supple, no lymphadenopathy. Full ROM of the neck, no numbness. Heart: RRR. Lungs: Clear, no wheezes heard. Gastro: Soft, nontender, no organomegaly or masses. Neuro: Nonfocal, within normal limits.

Labs: Blood glucose obtained due to Fam HX. Results: Blood glucose level 315.

Assessment: Hyperglycemia, most likely diabetes considering strong family history.

Plan: After a long discussion with mom regarding patient's extremely elevated and critical blood sugar level, and potential issues if not addressed, the plan is to admit to Children's Hospital for diabetes workup. Admit orders were phoned in and mom will transport patient to Children's Hospital.

Note 3

CC: Patient Three, DOB 4/19/2000, is a healthy 13-year-old girl. She is seen in my office for an initial evaluation and treatment of a lesion on her right forearm which has been present for approximately one year. She was a patient of Dr. Jones, who referred her to me for treatment. It is the patient's feeling that the lesion is getting bigger. On exam, the lesion measures between 1 and 1.5 cm, closely adherent to the overlying dermis along the proximal aspect of her right forearm.

After obtaining informed consent from her mother, the patient was brought into the procedure room and placed in a prone position. The areas surrounding the lesion were infiltrated with 1% Xylocaine with 1:100,000 epinephrine to which 1 to 10 dilution of sodium bicarbonate had been added for pH adjustment. After prepping and draping in the routine fashion, the procedure was begun by an incision along normal skin tension lines, directly overlying the nodule. Dissection was carried down to the level of the lesion, which appeared to be of an epidermal origin. The lesion was removed with its surrounding capsule and passed off the field for pathologic examination. The wound was then checked for hemostasis and closed using a Dermabond and Steri-Strips. Sterile dressings were applied to the incision lines, and the patient left with her mother.

Note 4

How would you code the following note, which was created using an electronic health record (EHR)?

PATIENT: Mary Smith
DATE OF BIRTH: 1/23/1945
DATE: 11/7/2011
Reason for visit: possible UTI

Medication brand	Start date	Date last reviewed	SIG description
Toviaz	4/28/2011		Take 1 tablet (8 mg) by oral route every day
Low-dose aspirin EC	2/14/2011		Take 1 tablet (81 mg) by oral route every day
Utira-c	2/14/2011		Dose unknown
Detrol LA	2/14/2011		Take 1 capsule (4 mg) by oral route every day
Coumadin	2/14/2011		Dose unknown
Levoxyl	2/14/2011		Dose unknown

A dictated note contains rich details that tell the story of why the patient is being seen.

Subjective

Patient here for evaluation of abdominal pain that extends down both legs
Dysuria, urgency and frequency
No gross hematuria
No recent antibiotics, symptoms have improved in the past on Cipro
Uribel no improvement
Vaginal irritation
No flank pain

Objective

UA: blood trace, WBC trace
BVI: zero
September 19, 2011-urine culture no growth
CT abdomen and pelvis with contrast September 2009 negative
Cystoscopy June 2009
Abdomen soft nondistended mild right lower quadrant tenderness
Back no CVA tenderness
GU: vaginal atrophy

Assessment

Abdominal pain
Bilateral extremity pain
Dysuria
History recurrent UTI
Urgency and frequency

Plan

Urine culture: Cipro 250 mg x 3 days
Estrace cream
May need catheterized urine culture
Follow up with PMD and pain clinic regarding extremity pain
Electronically signed by Dr. Adams 11/7/2011 9:06 AM
Document generated by Dr. Adams 11/7/2011 9:06 AM

The coder's point of view

The following summaries describe the CPT and ICD-9 codes that I would select and the documentation and details that affected my choices, as well as concerns and comments about the quality of the documentation included in the sample notes.

Although a discussion of ICD-10 coding is beyond the scope of this article, be aware that the documentation details required for accurate diagnosis coding will only increase when ICD-10 is implemented in October 2014.

Note 1 summary

CC: headache.

HPI: about a week (duration); stress (associated sign/symptom); neck (location); sore (quality).

ROS: tight shoulders (musculoskeletal).

PFSH: mother has history of migraines (family); getting married, yoga (social).

Overall history: expanded problem-focused (4 HPI, 1 ROS, 2 PFSH).

Examination: 1995 guidelines – a limited examination of affected body area or organ system and other related systems (constitutional, lymphatic, respiratory, musculoskeletal); 1997 guidelines – 2 bullets on general multisystem exam, problem focused.

Medical decision-making (MDM): moderate complexity; new problem to examiner, no additional work up; no data reviewed; acute uncomplicated illness/injury and prescription drug management.

CPT code: 99213 for an established patient or 99202 for a new patient.

Diagnosis: 307.81 (tension headache).

Concerns. Documentation does not indicate whether this is a new or established patient. This detail should be included in a heading or in the body of the note so that it would be apparent to a reviewer. The use of “negative” in the TM and neck examination is vague. It is better to include what was examined and found to be negative (e.g., TM negative for perforation, no cerumen, no redness, throat – no cobblestoning noted).

Comments. A dictated note contains rich details that tell the story of why the patient is being seen. This documentation contains patient-specific information that supports a comprehensive HPI and PFSH. However, because the ROS only covered one system, the overall level of history can't be any higher than expanded problem focused. If the patient was asked about symptoms, such as blurred vision or nausea, affecting other systems, it was not recorded. This additional information could have helped to support a detailed history (see box, page 26), which would have justified coding one level higher, assuming that the medical necessity was evident.

Note 2 summary

CC: nausea.

HPI: past three months (duration); frontal (location); mild (quality). ➤

ROS: headache (neurological).
PFSH: recently moved (social); maternal
GM and paternal GF have DM (family).
Overall history: expanded problem-focused
(3 HPI, 1 ROS, 2 PSFH).

Examination: 1995 – eight or more systems,
complete; 1997 – at least six elements identi-
fied by a bullet, expanded problem-focused.

MDM: High; new problem to examiner
with additional workup planned; review and/
or order of clinical lab tests; acute or chronic ill-
ness that poses a threat to life or body function.

CPT code: 99202 if the physician did not
follow the patient in the inpatient setting.

Diagnosis: 790.29 (hyperglycemia); V18.0
(family history diabetes mellitus).

Concerns. The note mentions that a “long
discussion” took place with the patient’s
mother but doesn’t record the total time of
the visit. If the physician had included that
information, as well as documentation of what
was discussed and whether more than half of
the total time was devoted to counseling or
coordination of care, the visit may have been
billable at a higher level based on time.

It is also not clear whether the physician
would follow the patient in the inpatient set-

ting or refer the patient to a physician of a dif-
ferent specialty. If the physician admitted the
patient, the physician would document the
history and physical upon admission at the
hospital, and the appropriate hospital admis-
sion code in the 99221-99223 series would be
billed rather than the office visit. If documen-
tation did not support the lowest level admis-
sion code (99221), a subsequent hospital care
code would be used.

Comments. The history is well-docu-
mented and again contains details that tell the
story. In this example, using the 1997 exam
guidelines would yield the same level of ser-
vice as the 1995 guidelines.

Note 3 summary

Concerns. The documentation of the
encounter is very brief. There are three ele-
ments of HPI, but the note lacks the ROS
and PFSH. There is a problem-focused exam
of the lesion, but the note doesn’t include
MDM information indicating findings and
treatment options.

The lesion’s size is documented as between
1 cm and 1.5 cm, which creates a problem

Documenting
for correct code
selection requires
attention to detail.

The note should
clearly indicate
whether the
patient is new or
established.

Documentation
of visits involving
“long discussions”
should include
the length of the
visit and subjects
discussed – to
enable billing at a
higher level.

HISTORY: A COMMON PROBLEM AREA

In my experience, physicians seem to do a better job meeting the documentation requirements for the exam and medical decision-making than for the history; I’m more likely to find problems in the history portion of the note than elsewhere. Missed elements of the history can be quite costly. For instance, in documenting a visit that merits a 99205 code, which requires the history, exam, and medical decision-making at the same high level, forgetting to document one element of the history of the present illness (HPI), review of systems (ROS), or past, family, and social history (PFSH) could drop the visit two levels to 99203. Here’s a quick review:

- The HPI is made up of eight elements: duration, location, modifying factor, quality, severity, timing, context, and associated signs and symptoms. (See “Documenting the 5 W’s and H,” page 27, for an HPI-related tip.)
- The ROS focuses on systems directly related to the presenting problems. The patient can provide this information verbally or by writing it on a form. The documentation must include the date of review and the physician’s initials or signature before it can be referenced and counted toward the level of service.
- The PFSH is a review of the patient’s relevant medical history. Past history includes the patient’s personal medical history of illness, operations, injuries, and treatments. The family history records relevant medical events of the patient’s family, which could put the patient at risk in relation to the presenting problem. The social history is an age-appropriate review of past and current activities that may include use of tobacco, alcohol, or drugs, marital status, employment history, or education.

Only information pertinent to the present encounter should be reviewed and documented. While it may be appropriate for the HPI to contain four elements, a comprehensive ROS and PFSH may not be pertinent in relation to the patient’s condition.

Practices may find the volume of documentation increasing as electronic notes and their templates become more common.

when assigning the procedure code. The procedure code will be submitted based on the diagnostic findings of the pathology report. A lesion between 1.1 cm and 2.0 cm would generate one procedure code while a lesion of 1.0 cm generates a different one. Without the specific size of the lesion, the lesser code would have to be reported.

Comments. This patient presents for evaluation and treatment of a lesion. There is not sufficient documentation of the HPI, ROS, exam, and MDM to support billing a separately identifiable evaluation and management service in addition to the lesion removal. The relative value units assigned to the lesion removal code assume that a brief assessment was performed prior to the procedure.

Note 4 summary

This documentation is from a computerized system. It lacks information to identify whether this is a new or established patient, so we will review this note in both cases.

CC: possible UTI.

HPI: both legs (location); uribel (modifying factor); no gross hematuria (quality); vaginal irritation (associated sign and symptom).

ROS: Because the documentation does not include a review of systems, the remaining HPI is used: GU (dysuria); musculoskeletal (no flank pain).

PFSH: none.

Overall history: expanded (4 HPI, 2 ROS, no PSFH).

Examination: 1995 – a limited exam of affected body area or organ system and other related organ systems (GI, GU, musculoskeletal); 1997 – documentation does not contain enough elements to use the genitourinary exam guidelines. Two bullets counted using the general multisystem exam guidelines. In either case, documentation limits the level of exam to problem focused.

MDM: moderate complexity; new problem to examiner; no additional workup planned; labs and CT reviewed; one or more chronic

illnesses and prescription drug management.

CPT code: 99202 for new patient or 99213 for established patient.

Diagnosis: 789.00 (abdominal pain); 729.5 (extremity pain); 788.1 (dysuria); 788.63 (urinary urgency); 788.41 (urinary frequency).

Concerns. A prescription was given for Estrace cream, yet the assessment does not describe the related condition or diagnosis code.

Many of the rich details we find in a dictated note are lost in the templated electronic note.

Ongoing medications are documented in the note. However, the date when the list was last reviewed is not included, which an auditor may take to mean that the medication list has never been reviewed or updated.

Comments. Compare the electronic note to this earlier dictated note on the same patient: “Chief complaint: History of recurrent UTIs, pelvic pain, frequency, urgency. Patient for the last two days has been experiencing urgency and frequency. She feels her urine has been dark, and she is concerned she may have a UTI. When she can take Toviaz, she claims she is almost completely asymptomatic. Unfortunately, she cannot afford Toviaz. She has had a few samples here and there and done very well with them. She has grossly infected urine today on micro. I found her

Physicians should document whether they will follow the patient in the inpatient setting or refer to another physician.

Electronic templates may produce notes that lack some of the helpful details found in dictated notes.

Include a date to indicate when the patient’s medication list was reviewed.

DOCUMENTING THE 5 W’S AND H

Have you thought to use “who, what, when, where, why, and how” in your documentation?

WHO (patient): Each note should contain at least two patient identifiers, such as name, date of birth, or medical record number.

WHAT (reason for encounter): Is this a preventive or problem-oriented visit? If it is for an illness or problem, each visit should contain a chief complaint, which is typically recorded in the patient’s words.

WHEN, WHERE, WHY, HOW: These cover essentially the same ground as the eight elements of the history of present illness. You may find them easier to remember than duration, location, modifying factor, quality, severity, timing, context, and associated signs and symptoms.

Documentation requirements have not changed with the use of electronic health records.

a free two-month Toviaz prescription. Will await results of her culture before putting her on antibiotics. Call Monday for culture report.”

The dictated note uses descriptive words, which paint a more detailed picture.

■ Not including key details forces coding staff to seek additional information.

■ Proper documentation also improves patient care.

Findings

The first two notes are generally well documented and contain specific information relating to the patient and the presenting problem. However, each note lacks details that could contribute to downcoding. Resolving these issues would require the coding staff to seek additional information from the physician, which would reduce the efficiency of the claims process. The third note is not as thorough and, as a result, only the procedure is billable.

Practices may find the volume of docu-

mentation increasing as electronic notes and templates become more common. However, as seen in the fourth note, the quality of documentation continues to need attention. Documentation requirements have not changed with the use of EHRs.

Regardless of the format, detailed documentation is instrumental in supporting the medical necessity of services, making sure the correct levels of service are billed, and demonstrating and facilitating quality patient care. If you are doing the work, don't forget to include it in your documentation. **FPM**

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