SIMPLIFY DOCUMENTATION OF HISTORY AND PHYSICAL EXAM FOR INPATIENT CODING

While history and physical exam are no longer necessary for coding outpatient evaluation and management (E/M) office visits, they are still key components of inpatient and nursing home visits. When coding encounters that still rely on history, the following tips can help family physicians chart more efficiently:

• You do not need to personally do all of the documentation. Ancillary staff can record past medical history, family history, social history, and review of systems as long as you document that you reviewed it.

• You do not need to re-record information from a previous encounter as long as you describe any changes or state that there is no change and provide the date.

• Past medical history, family history, social history, and review of systems may be included in the "history of present illness" or listed separately, but they can only be counted once.

• Remember that negative statements (e.g., "No history of cardiac disease") count toward family history, and social history should include both current and past activities that are relevant to health (e.g., past history of tobacco use in a patient who has since quit).

• For the physical exam, you may choose between documenting systems or bullet points. For systems, it is OK for your documentation to simply be "negative" or "normal."

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CAPTURE ALL OF YOUR TIME FOR OUTPATIENT E/M CODING

Since the beginning of 2021, all outpatient E/M office visits can be coded using either medical decision making alone or total time alone. Time-based coding should include all the time you spend on a patient before, during, and after the exam on the date of the visit (but not staff time). Tracking time for each visit may seem like a pain, but there are some ways to make it easier and ensure you're getting proper payment for your work.

> For systems, it is OK for your documentation to simply be "negative" or "normal."

Wait to finish your note. While delaying completion of your notes is not usually recommended, it may be worthwhile. If the record review will take an extended period, or if you anticipate discussing the case with another clinician, you may want to wait on the note because all of that work counts toward time as long as you do it before midnight on the date of the visit.

Use time trackers. Some EHRs have timers that automatically track how long you're logged in to a patient's chart. If your system has this feature, keep the chart open while you're reviewing records before the visit or talking to another clinician about the case afterward.

Note the length of phone calls. Most office phones and cell phones record the exact amount of time you spent on a call. If you don't have a time tracker on your EHR (or you forgot to have it open during a call), this is an easy way to capture that time accurately.

Recognize tasks with "baseline times." There are some tasks you can safely assume will take a certain amount of time based on your experience. For instance, it may take you a minimum of two minutes to check your state's prescription drug monitoring system. If you're two minutes short of the next time-based coding threshold, that's an easy thing to add. Other "baseline time" tasks may include specific types of documentation, such as Family and Medical Leave Act paperwork.

Source:
Church SL. Tips for using total time to code E/M visits in 2021. *FPM* Getting Paid blog. Nov. 23, 2020. Accessed Oct. 26, 2021. https://www.aafp.org/journals/fpm/blogs/gettingpaid/entry/total_time_tips.html

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