General Coding Documentation Tips – Do’s and Don’ts

Source: The Physician Compliance and Monitoring Manual

There are many approaches to documentation of services that will go a long way towards ensuring compliance. Much of this is common sense while some may not be as obvious. Find below some basic tips.

**Do Use Templates to Assist in Documentation**
The history and exam portions of the encounter are often the source of missing elements or areas associated with the code chosen. While the code may be correct relative to the overall level of decision making, it may be missing some aspect of history or exam required to support the code from a documentation perspective.

Templates are a useful way to record ‘normal’ exam findings, to update Past, Family and Social History, or to serve as a prompt to providers for the elements of an encounter that need to be documented. Printed templates are the precursor to the electronic medical record – get used to the idea.

**Don’t Misuse Templates**
Templates can be easily abused by practices such as checking off all exam items or drawing lines through entire ranges or organ systems. The history sections can be summarily addressed and neglect to include the date that, for example, the past history was updated from. Templates are useful to assist in documentation, not replace it. The documentation needs to be in proportion to the reason for the visit – a level five or comprehensive exam for an acute single-system illness or problem strains credibility – where is the medical necessity in this. Templates can drive this type of misuse.

**Do Be Certain the Provider Addresses the HPI**
Recent clarification by CMS indicates that the History of Present Illness must be addressed in some fashion by the provider. Although ancillary staff, nurses, and nurse medical assistants record ROS and PFSH, the provider must either perform or indicate specific knowledge of the HPI. If an entire HPI is not repeated when taken by other staff, at the very least the provider should indicate “HPI as above significant for xxxxx.” This is borrowed from the teaching guidelines but should suffice to meet the standards.

**Do Remember that New Patient and Consult Codes Require All Three Components of E/M**
Because the established patient codes often comprise the bulk of a physician’s services, providers can get into the habit of documenting either history or exam at a certain level. Frequently an exam will be fairly complete, but only address six of seven organ systems. The higher levels, four and five, of new patient and consult codes require a comprehensive exam, and a comprehensive history. The very nature of a new patient of consult type encounter will necessitate the taking of greater history – but be certain it is complete enough.
**Don’t** treat new and established patient documentation the same.

**Don’t** allow ancillary histories to stand alone without provider commentary and additions.

**Do** Make a Rule for Your Providers That for Established Patients, of the Two Required Components of E/M – Medical Decision Making Is One of Them

The rule that requires only two of three E/M components for an established patient visit can be dangerous. The safest way to view this is that either the history or exam will act as the supporting performance and documentation element of the correct level of service based on medical decision-making. Make sure decision-making is one of the two – it will keep the encounter rooted in medical necessity. Technically, if a comprehensive history and physical was performed with a low-level presenting problem, the encounter could be coded as a level five. This would not however meet medical necessity standards. The documentation should always be in proportion to the service required.

**Don’t** rely on beefy histories and exams alone to support high-level services.

**Do** Make Certain Decision Making Is Clearly Documented

The key to code selection and ironclad documentation of the critical element of E/M is here. In most cases when decision-making at a certain level occurs, the degree of history and exam will follow. Most efforts to teach physicians these documentation rules put the cart before the horse so to speak, and attempt to teach all the different elements of history and exam before decision-making.

Physicians should be encouraged to identify the level of service in the first few moments of the encounter. The table of risk and decision-making matrices in all versions of the Federal Documentation Guidelines give a range of acuity from uncomplicated through critical episodic presentations. They also list a quantitative progression of chronic conditions. In most cases, the physician will know early in the encounter what types of problems are being presented, or how many problems are to be addressed. Even when confronted with an unknown new problem, this is clearly earmarked as at least moderate level decision making. Of course, some encounters may take a dramatic turn after the initial presentation, but most do not. Often not documented are the differential diagnoses, rule-outs, and potential morbidity/mortality problems. List these under ‘impression’ or ‘course’.

Document for each problem encountered, the problem or condition, the status of the problem i.e., well-controlled, worsening etc, and the management options. Give the regulator what they are looking for. In the assessment and portion of the chart simply state “HTN” well controlled continue Toprol,” or “COPD exacerbation consider O2 Tx.”

**Don’t** simply state “continue present meds” or “follow-up in 3 months.”

**Do** Address Teaching Physician Guidelines

A safe harbor approach is to have the attending physician weigh in on each aspect of the encounter, ‘History as above significant for……, on my exam…..and management includes……’ Leave no doubt as to attending physician’s involvement.

**Don’t** rely on the old “seen and agree.”
Clarify Oversight When 99211 is Coded

**Do** be certain that providers sign off and are involved in 99211 service.

**Don’t** assign 99211 codes to services the provider did not participate in, and sign off on.

**Do** be certain that ‘incident-to’ services are appropriately overseen and counter-signed.

**Don’t** use a physician provider number when they are not present or available (payer-specific).

Document Appropriately When Modifier – 25 Is Used

Since the definition of modifier – 25 is “separate, significant and identifiable service provided on the same day as a procedure or other service”, make sure the documentation addresses each of these. When two services are provided, e.g., “visit and procedure,” or, as above, “medical visit and health maintenance, “break the chart into two sections. Label these sections “procedure,” and “maintenance and medical management.” Leave no doubt for anyone who checks what was done. If you have two services, document two services. Learn when only one can be charged.

**Don’t** add an E/M visit to every office procedure performed (this is quite common).

**NOTE – For all provider types:** Remember that hospital admissions require comprehensive histories and exams at the two higher levels of admits. Much Federal auditing is done for these services, precisely because this is where documentation deficiencies often occur. All admits levels Two and Three require a complete (10) ROS! This area probably yields more deficiencies than any other. Hospitals generally require a complete “H&P”; don’t forget this history element. Under current guidelines this can be met by indicating “all other ROS negative” after reviewing problem – pertinent systems, assuming the other systems were reviewed.

The same goes for subsequent hospital visits. Here the exam is often not very substantial (the patient just having a had a ‘complete’ H&P on admission), but do not overlook it. It is almost always best to use the general system-level approach here. Key history tips here are to mention the interval history, i.e. “taking po better, afebrile, responding well to xxxx”. Many subsequent hospital notes are scanty to say the least. This is a prime risk area.