Understanding Documentation Requirements

Kelley Godin, CCS
Coding Manager, MMC
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Objectives

- Purpose of documentation
- CMS Guidelines
- Coding Terminology
- Resources

Purpose of Documentation

- Shows chronology of treatment
- Communication tool between practitioners
- Support medical necessity
- Quality of care
- Collection of data
- Medicolegal issues
- Reimbursement

General Principles of Documentation

- Medical record should be complete and legible.
- Documentation should include:
  - Chief complaint
  - Exam and diagnostic test results
  - Assessment
  - Plan

CMS Guidelines

- New versus Established Patient
- Consultations
- Levels
- Counseling
- Medical Necessity

New vs. Established Patient

- A new patient is one who has not received any professional services from the physician, or another physician of the same specialty who belongs to the same group practice, within the past three years.
- An established patient is one who has received professional services from the physician, or another physician of the same specialty who belongs to the same group practice, within the past three years.

Consultations

- Provided at the request of another physician or other appropriate source for the purpose of rendering an opinion or advice regarding the evaluation and management of a specific problem.

Consultation Rules

- Requests must come from an attending physician or other appropriate source, and the necessity for the service must be documented in the patient's record.
- The consulting MD should provide communication regarding his/her findings to the requesting MD.
- The consultant may initiate diagnostic and/or therapeutic services, such as writing orders or prescriptions and initiating treatment plans.
- The opinion rendered and services ordered or performed must be documented in the patient's medical record and a report of this information communicated to the requesting provider.

Components of E/M Visits

- History
- Exam
- Medical Decision Making
- Counseling
- Coordination of Care
- Nature of Presenting Problem
- Time

HPI Elements

- Location
- Severity
- Timing
- Quality
- Duration
- Context
- Modifying Factors
- Associated Symptoms

Review Of Systems

- Constitutional
- Eyes
- ENT
- Cardiovascular
- Respiratory
- GI
- GU
- MS
- Integumentary
- Neurological
- Psychiatric
- Endocrine
- Hematologic
- Lymphatic
- Allergic/Immunologic

Past, Family, Social History (PFSH)

Past

- Immunizations
- Current Meds
- Allergies
- Hospitalizations
- Surgery
- Illnesses
- Injuries

Family

- Parents, Siblings, Children

Social

- Marital Status
- Living Arrangements
- Occupational & Sexual History
- Drugs, Alcohol

Physical Exam

10 Areas

- Head/Face
- Neck
- Chest (including breasts & axillae)
- Abdomen
- Genitalia/groin/buttocks
- Back/Spine
- Each of the four Extremities

Physical Exam
12 Systems

- Constitutional
- Eyes
- ENT
- CVS
- Respiratory
- GI
- GU
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Heme/Lymph/Immune

Decision-Making Criteria

Scope of Differential Diagnoses

- "Diagnosed" vs. "Undiagnosed" Problem
- Extent of Work-up Required
- Consultation Required

Level of Risk

- Intrinsic to Illness
- Related to Procedures
- Related to Therapy

Extent of Data Analysis

- Lab or Pathology (1)
- Radiology (1)
- Other tests (EKG, PFT) (1)
- Discussed with radiologist, etc. (1)
- Review & ***Summary*** of prior records and/or other data (i.e., hx from family) (2)
- Independent visualization (2)

New Patient Levels

	99202	99203	99204	99205
HPI	1-3 elements	Extended – 4 or more elements or associated comorbidities		
ROS	1 system (including main affected system)	2 or more systems (including affected system)	10 or more systems (including affected system)	
PFSH	Not Required	At least 1 from <u>any</u> of the 3 areas	At least one from <u>each</u> of three areas	
PE	2 or more body areas and/or organ systems	5 or more body areas and/or organ systems	8 or more systems	
MDM	Straightforward Complexity Or Risk is Minimal	Low Complexity Or Risk is Low	Moderate Complexity Or Risk is Moderate	High Complexity Or Risk is High

Established Patient Levels

	99212	99213	99214	99215
HPI	1-3 elements	1-3 elements	4 or more elements or associated comorbidities	4 or more elements or associated comorbidities
ROS	1 system (including main affected system)	1 system (including main affected system)	2 or more systems (including affected system)	10 or more systems (including affected system)
PFSH	Not Required	Not Required	At least 1 from any of the 3 areas	At least 2 from any of the 3 areas
PE	2 or more body areas and/or organ systems	2 or more body areas and/or organ systems	5 or more body areas and/or organ systems	8 or more systems
MDM	Straightforward Complexity Or Risk is Minimal	Low Complexity Or Risk is Low	Moderate Complexity Or Risk is Moderate	High Complexity Or Risk is High

Time Matters!

- The American Medical Association Guidelines
  - When counseling and/or coordination of care dominates (**more than 50%**) the physician/patient and/or family encounter (face-to-face time) then time may be considered the key or controlling factor to qualify for a particular level of E/M services

Documentation of time is key if time is the determining factor

- The total amount of time spent with the patient must be clearly documented
- The record should describe the counseling and/or activity to coordinate care
  - "A total of 30 minutes was spent with the patient, more than half of this time was spent discussing treatment options and subsequent effects of chemotherapy."
  - "More than half of the time was spent counseling the patient on the risks of cigarette smoking and cessation options."

Medical Necessity

- Medicare outpatients only.
- Typically lab or approved screening tests
- Websites
  - http://www.cms.hhs.gov/mcd/index_list.asp?list_type=ncd
  - http://www.ahsmedicare.com/provider/disclaimer.asp?Target=/provider/review_appeals/view_active_policies.asp?

Clinical vs. Coding Terminology – Diagnosis Coding

- Probable, likely, suspected, rule out, possible
  - For office visits and other outpatient services Coding Guidelines dictate that a coder can not code the above, rather would need to code the symptoms

Clinical vs. Coding Terminology – Diagnosis Coding (cont'd)

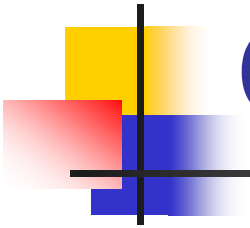
- Disease specificity
  - Coder's are not allowed, by Coding Guidelines, to make clinical assumptions
  - Practitioners should document to the highest degree of specificity patient conditions

Disease Specificity

- Diabetes & Diabetic Manifestations
  - Type I vs. Type II
  - Controlled vs. Uncontrolled
  - Need to connect manifestations to DM
- CHF
  - Acute vs. Chronic
  - Systolic vs. Diastolic
- Hypertension and heart disease
  - If heart disease is due to HTN must document connection (i.e. Hypertensive cardiomyopathy; congestive heart failure due to HTN)
- History of

Resources

- www.cms.hhs.gov/MLNProducts/downloads/eval_mgmt_serv_guide/pdf
- www.cms.hhs.gov/MLNEdWebGuide
- http://www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/ftpicd9.htm
- AMA's Physicians' Current Procedural Terminology



Questions???