Eli's Rehab Report

E/M Focus: Boost Your Bottom Line With These 4 Documentation Steps

Tip: Don't miss the endocrine system when you're tallying ROS

One missed documentation element could mean the difference between reporting **CPT 99212** and 99213--and $8 in lost revenue for every downcoding you do. Our experts weigh in on how to code E/M office visits correctly and increase your bottom line.

How often do you pull a chart and think, "If the physician had simply written down a little more information or asked about another system, he could have coded a level-four visit"?

The problem: "I feel that our physicians are cautious in coding higher levels," says **Babette Christofferson**, **CCS-P,** coding and billing specialist at Scottsbluff Physiatry Associates and Regional Neurology in Scottsbluff, Neb. "We've had consultants come in and audit charts, and most often our physicians tend to undercode rather than overcode"--which translates to a loss of revenue for the services that your physiatrist provides.

Often physiatrists are stingy on documentation in key areas. They ask the appropriate questions and perform the service, but they don't document the question-and-answer portion very well. "I have a physician who rarely documents past, family or social history, another who documents past medical only, and another physician who documents only past and social. One provider will even just document 'patient's past medical history is reviewed,' " Christofferson says.

Here's how to escape these problems:

Step 1: Create a Template

One way to ease your documentation challenges is to create a form that targets the four types of history. The physiatrist needs a tool to trigger her memory so she'll record all pertinent information.

Success story: "I've had a provider use a template, which worked well. His documentation is very much in order and precise," Christofferson says. "Physicians don't go to school to be good dictators. We're here to help them and give them the tools necessary for accurate reporting of the work they perform."

The form should include under the subjective (S) or history area:

- CC (chief complaint)
- HPI (history of present illness)
- ROS (review of systems)
- PFSH (past, family, social history).

Step 2: Highlight Your HPI

In addition, you shouldn't let the HPI element stand in the way of that higher E/M level.

Example: The patient complains of back pain that has lasted two weeks. If this is all you know, you may have to report a problem-focused code because the statement only includes two criteria for HPI (location of pain and duration), says **Julee Shiley, CPC, CCS-P, CMC**, a coding consultant in Columbia, S.C.

A thorough look at the patient's condition means understanding the problem from start to finish: discussing signs and

symptoms from their onset through the present visit, or getting details about changes since the previous encounter. Putting together a complete history includes asking questions about the chief complaint, including:

• The location (where anatomically)
• The quality (what it looks or feels like, such as throbbing, sharp, radiating, etc.)
• The severity (how bad or better the problem is and/or pain based on a scale of 1-10)
• The duration (how long the problem has been present)
• The timing (when the problem occurs, such as after walking, after sitting for prolonged times, continuous, etc.)
• The context (what the patient was doing when he first noticed the problem, such as walking, lifting something heavy, no specific onset)
• Any modifying factors (what makes the problem better or worse, such as lying down, taking ibuprofen, walking)
• Any other signs or symptoms that are present (numbness, tingling, fatigue, leg pain, urinary problems).

All you need is 4: Documenting four or more of these details indicates your provider questioned the patient to help with the diagnostic process and attained an extended history of present illness. You physiatrist may commonly ask these types of questions, but just not document them well.

In the example above, you already know the patient's pain has lasted two weeks. Answers to a few questions show that he doesn't remember exactly how the pain began--"just woke up with it one day," but a dull ache is always present. The patient ranks his pain now as a 7 on a 0-10 scale. Standing for long periods makes his back pain worse and also makes him have tingling in his lower leg. Lying down and taking ibuprofen helps relieve the pain to some extent.

Now you know much more about his condition to help your coding:

• Location of pain (back)
• Quality of pain (dull, but sometimes sharp)
• Severity of pain (7 on a scale of 10)
• Duration of pain (2 weeks)
• Timing of pain (constant)
• Context of pain (just woke up with it)
• Modifying factors affecting the pain (lying down and taking over-the-counter medication)
• Associated signs and symptoms of pain (tingling in lower leg).

Break it down: Coding from this more thorough description may move you from a lower-level E/M code (such as 99212) to a more detailed, higher-level code. The visit might even qualify for a level-four code such as 99214 (... a detailed history; a detailed examination; medical decision-making of moderate complexity).

Step 3: Focus on 3 ROS Pitfalls

Avoid these three ROS pitfalls to earn the correct E/M level every time.

Pitfall 1: Don't miss the endocrine system. This is one of the most frequently overlooked systems, says Jo Anne Steigerwald, senior consultant with the Wellington Group in Valley View, Ohio. If the physician asks questions about weight gain or loss or skin dryness, these frequently relate to the endocrine system, she says. So do questions about whether the patient feels constantly too hot or too cold. These questions may help to identify a thyroid problem, she say.

But by contrast, questions about dizziness, weakness, tingling or shakiness should count toward the neurological system, Steigerwald say. And notes about swelling under the chin or neck or skin that bruises easily should count toward the hematologic/lymphatic system.

Pitfall 2: Don't overlook the psychiatric system. If the physiatrist asks questions about the patient's mood or notes that the patient has been more cheerful or depressed lately, then you can count this toward the psychiatric system, Steigerwald says.

Pitfall 3: Recognize that some questions may apply to more than one system. Muscle weakness could be a musculoskeletal or neurological issue, experts say. Likewise, a question about abdominal status could relate to the endocrine system because the pancreas is there, or the concern could be gastrointestinal. A question about sleep patterns could be neurological or constitutional. But you can never credit a single statement to two systems, Christofferson says.

Step 4: If Appropriate, Don't Neglect PFSH

Past history refers to the patient's own medical history, including current medications and allergies. Family history includes medical events in the patient's family-line, such as familial rheumatoid arthritis or diabetes. Social history, alternatively, reviews the individual's past and current activities (for example, occupational history or use of drugs).

"What sticks out to me when I'm reviewing a chart is PFSH," Christofferson says. "A quick note about family or social will help add to the history."

Keep in mind: Your physiatrist will likely ask established patients about their current medications (past history) and social history (are you working, how are you functioning, what are you able to do, and so on). Questions regarding family history may not be appropriate, particularly if your physiatrist already addressed this at the initial patient visit.