OP Coding Decision Support
What it can and cannot do to assist you

What does Office Practicum's Coding Decision Support do?
OP's Coding Decision Support "counts" items of documentation and based on countable information suggests the most appropriate E/M coding level based on information that was recorded for a particular visit. The calculation is based on CMS's **1997** guidelines.

I've heard that the 1995 CMS coding guidelines are more pediatric friendly, can I use those?
The 1995 guidelines are much more difficult to computerize and calculate with "counting" of specified documentation areas, therefore the more recent 1997 guidelines were used in the coding decision support.
The **provider who does the visit** is responsible for determining the most appropriate coding level. This is a CMS guideline. If you are very familiar with the 1995 guidelines, just as you did on paper, you are free to use them, but Office Practicum cannot assist you in that calculation. In addition, the audit note will not assist you if you are audited. The note you generate for the visit will need to stand on it's own if audited and you were using the 1995 guidelines.

Why can't I always just use the code that the OP decision support suggests?
The decision support calculator is just counting documented items. It cannot determine if what you documented is pertinent to the reason for the visit. In order to be valid, information documented must be reflective of the reason for the visit. So while you may "get credit" from the calculator for reviewing past medical history, social history and family history because you "checked the boxes", if it is not pertinent to the reason for the visit (for example, simple insect bite to the arm) then the fact that you reviewed that information should not be considered in selecting the most appropriate E/M code.

The computer was not watching the provider ask questions or examine the patient. If you apply templates that include ROS questions that were not asked, or physical exam elements are part of the template but the provider did not examine that body part, the provider must edit the note to include the appropriate information. The calculator will give credit for what is documented in the note. If challenged, it is the provider's responsibility to make sure the note reflects the actual work done.

In addition, complexity of Medical Decision is one of the 2/3 areas (History and Physical Exam being the other two) that must be considered in choosing an appropriate coding level. (And for **new** patients all 3/3 sections must be considered!) The computer cannot know the number of differential diagnoses you considered, how many relevant diagnostic tests were reviewed, and what is the potential for complications. Only the provider can know that information.

If you are converting from paper to the computer, or you are updating a patient chart for reasons not related to the encounter, and you enter information on social, family or past medical history,

because you entered data in these sections the calculator may add that information. Only the provider can know whether or not that information is actually relevant to the reason for the visit.

How can I best utilize OP's Coding Decision Support?
One of the ways that the coding decision support can be most helpful, is in selecting the most appropriate code based on time, either care coordination or counseling. The CMS time-based coding rules include use of the code that is "closest" in time. These time-based rules are incorporated into the coding decision support calculator. It is critical to understand all of the fields to fill in to be sure the total length of visit and the time spent counseling/coordinating is recorded to fulfill review/audit requirements.

The coding calculator is also helpful to review where documentation may be insufficient to support a coding level which the user believes is appropriate for the visit. The provider may know that the work they did was "worth a 99214" but the coding calculator may point out to them that they forgot to include the pertinent check box on a family history item, or don't have enough exam elements to meet the level of a 99214.

The coding calculator is also helpful to document the complexity of medical decision making for an audit note. Remember: ALL NEW visits, require 3/3 sections to meet the level of complexity when choosing the most appropriate E/M coding level.

Regardless of the level of E/M coding chosen, it is always the provider who is ultimately responsible for knowing the coding rules, choosing the most appropriate code and reviewing the note summary to make sure it reflects all of the detailed information necessary to support the chosen code in the case of a review or audit.