

Coding and Documentation Frequent Gotchas

Below are some examples of OP User real experiences from audits that demonstrate best practices and proactive documentation.

History Information reviewed but not medically pertinent:

Remember that if you update information, it will be counted on the coding calculator but it *must be pertinent* to the reason for the visit. For example, a child comes in for eczema, and the mom reminds you, “Oh by the way, Johnny had his strabismus surgery last Friday.” Eye surgery has nothing to do with eczema.

You update the past medical history, but since this is not pertinent to the reason for the visit, you want to make sure that you do not check the box for Past Medical in the “pertinent history reviewed” *nor* check the “pertinent box” to the right of the strabismus box as demonstrated in the screenshot below:

(**Note:** prior versions of OP sometimes “auto-checked” this information if you were documenting new information.)

Pertinent history reviewed: ☒ Allergy ☐ Past Medical ☐ Family ☐ Social ☐ Perinatal

Past Medical History Family History Social History Perinatal History

☐ Show all questions

	History Question	Comment	Pert
Past Medical History			
-	Serious injuries or accidents		<input type="checkbox"/>
+	Surgeries	1/16 strabismus surgery (CHOP)	<input type="checkbox"/>
-	Hospitalizations		<input type="checkbox"/>
+	Other infectious illnesses	Hx MRSA cellulitis Methicillin resistant staphylococcus aureus carrier	<input type="checkbox"/>

If you were to check the pertinent box, the information would be include in the summary encounter (and audit note):

Primary Encounter Note **Patient Exit Note** Alternate Notes

CC: rash

HPI:
 Fever: None; Onset: >1 month; Duration: Intermittent; Quality: Worsening
 Breastfeeding history:
 Age of introduction of solid foods:
 Age of onset of skin symptoms:

ROS:
Constitutional: Denies fever/chills.
Eyes: Denies red eyes or eye drainage.
Integumentary (Skin/Breast): Reports rashes or dry skin. Denies pigmentation changes.
Medical Home: Reports updated individual care plan: Including daily use of moisturizer, assessed and identified barriers to achieving treatment goals, reviewed and updated information for prescriptions written, assessed understanding of medications, as management, discussed self-management goals/plans: Including minimizing flare-ups, management tools to record self care: office tools as well as phone app, counseling.

PFSHx:
 Allergies, Past Medical History reviewed and updated as appropriate, **pertinent** for
Past Medical History: Positive for **Surgeries: 1/16 strabismus surgery (CHOP).**
 Allergies/Reactions Reviewed by Susan Kressly (305) 02/07/2016 11:42:23
 - CLARITIN
 - AUGMENTIN

And counted in the coding calculator:

☐ New patient ☐ Telephone ☐ Online Coding count override: ☐ Recalc

History Documentation

HPI elements:	ROS categories:	Pert sections:	History summary:
<input type="radio"/> 1-3	<input type="radio"/> 1	<input checked="" type="checkbox"/> Medical	<input type="radio"/> Problem Focused
<input checked="" type="radio"/> 4 or more	<input checked="" type="radio"/> 2-9	<input checked="" type="checkbox"/> Family	<input type="radio"/> Expanded Problem Focused
	<input type="radio"/> 10 or more	<input type="checkbox"/> Social	<input checked="" type="radio"/> Detailed

Exam Documentation

Exam elements:	Vital signs measured: 0	Exam summary:
<input type="radio"/> 1-3		<input type="radio"/> Problem Focused

If checked, at least one specific family history item must be documented as pertinent to the problem in the HPI

However, an auditor could challenge this coding since the medical history checked is not medically “pertinent” to the reason for the visit.

History reviewed and pertinent but insufficient information:

Some auditors/reviewers specifically want documentation of what portions of the history were reviewed and specific information about pertinent/relevant medical information. If your staff or provider simply check history boxes as reviewed, the summary note/audit note will not

specifically give information about what material was pertinent, and this may be insufficient to meet their coding and documentation standards:

Pertinent history reviewed: ☒ Allergy ☒ Past Medical ☒ Family ☒ Social ☐ Perinatal

Past Medical History Family History Social History Perinatal History

☐ Show all questions

+ / -	History Question	Comment
<input checked="" type="checkbox"/>	Past Medical History	

Primary Encounter Note Patient Exit Note Alternate Notes

CC: rash

HPI:
 Fever: None; Onset: >1 month; Duration: Intermittent; Quality: Worsening
 Breastfeeding history:
 Age of introduction of solid foods:
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Medical Home: Reports updated individual care plan: Including daily use of moisturizers, assessed and identified barriers to achieving treatment goals, reviewed and updated medication information for prescriptions written, assessed understanding of medications, assessed management, discussed self-management goals/plans: Including minimizing flares and it management tools to record self care: office tools as well as phone app, counseled on in

PFSHx:
 Allergies, Past Medical, Family, Social History reviewed and updated as appropriate
 Allergies/Reactions Reviewed by Susan Kressly (365) 62/01/2016 11:42:23

To document pertinent information, it is necessary to choose a pertinent item and check the box:

+ / -	History Question	Comment	Pert
<input checked="" type="checkbox"/>	Past Medical History		
-	Serious injuries or accidents		<input type="checkbox"/>
+	Surgeries	1/16 strabismus surgery (CHOP)	<input type="checkbox"/>
-	Hospitalizations		<input type="checkbox"/>
+	Other infectious illnesses	Hx MRSA cellulitis	<input checked="" type="checkbox"/>
Methicillin resistant staphylococcus aureus carrier			

Past Medical History **Family History** Social History Perinatal History

Genetic mother: th mother/father (adopted) Copy Hx: ☒ All ☐ None ☐ No known family members 'No Family History'

Genetic father: JOHN TESTPATIENT Copy Hx: ☒ All ☐ None ☐ MARY / TEST EDITEST / TEST C EDITEST

Drag a column header here to group by that column

Family Member	Problem	SNOMED Code	DX Age	Notes	Copy To	Pert
Unknown	- inflammatory bowel disease		Unknown		None selected	<input type="checkbox"/>
Unknown	+ Ulcerative colitis	64766004	Unknown		None selected	<input type="checkbox"/>
Natural father	+ Allergic rhinitis	61582004	Unknown		MARY, TEST EDITEST, TEST C EDITEST	<input checked="" type="checkbox"/>
Maternal grandmother	+ Malignant tumor of breast	254837009	Unknown	deceased 2/12	MARY, TEST C EDITEST	<input type="checkbox"/>
Maternal grandfather	+ Malignant tumor of lung	363358000	Unknown	MOF (lung), MGM breast CA dx 3/10; deceased 2/12	MARY, TEST C EDITEST	<input type="checkbox"/>
Paternal grandmother	+ ECZEMA	43116000	Unknown		MARY, TEST EDITEST, TEST C EDITEST	<input checked="" type="checkbox"/>
Maternal uncle	+ Ulcerative colitis	64766004	Unknown		None selected	<input type="checkbox"/>
Half-sister	+ Asthma	195967001	Unknown		None selected	<input checked="" type="checkbox"/>

OR document it somewhere else in the note as free text and hand check the pertinent reviewed history section:

Note Editor Care Plans Prior Notes Templates All templates: ▼

Info CC: rash

HPI: Fever: None Location: >1 month Timing/onset: Intermittent Duration/pattern: S

Social hx: in daycare, recent travel to Mexico, smokers in home

Your encounter note and audit note will then contain sufficient information to justify the medical relevance of the information to the reason for the visit:

Primary Encounter Note	Patient Exit Note	Alternate Notes
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HPI:
 Fever: None; Onset: >1 month; Duration: Intermittent; Quality: Worsening
 Social hx: in daycare, recent travel to Mexico, smokers in home

ROS:
Constitutional: Denies fever/chills.
Eyes: Denies red eyes or eye drainage.
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PFSHx:
 Allergies, Past Medical, Family, Social History reviewed and updated as appropriate, *pertinent* for
Past Medical History: Positive for *Other infectious illnesses: Hx MRSA cellulitis.*
Family History
 • Natural father: *Positive for Allergic rhinitis*
 • Paternal grandmother: *Positive for ECZEMA*
 • Half-sister: *Positive for Asthma*

New patient visits coding level based on 2/3 sections of the note when it needs to be 3/3:

Many versions of OP's coding calculator do not insist that for new patients all 3/3 sections must be accounted for. This is a key coding basic that all providers should be aware of.

Diagnostic/Procedure Codes	Coding Decision Support	Coding Statistics
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Type of visit:

<input type="radio"/> Established	<input type="radio"/> Inpatient	<input type="radio"/> Consult
<input checked="" type="radio"/> New patient	<input type="radio"/> Telephone	<input type="radio"/> Online

Documentation supports: 99202
 Key component(s): 2/3
 Should be 3/3 Key components for new pts

History Documentation

Apply Recalc

Inadequate documentation of Medical Decision Making (MDM) complexity:

Best practices are always that provider "think out loud" in the note to justify medical decision making including diagnoses, differential diagnoses, information reviewed, and potential complications. Many users document the MDM complexity in the Assessment/Plan section of the visit.

Assessment:

DX 1: R53.83 Fatigue

DX 2: R04.0 Epistaxis

DX 3: R11.10 Vomiting, unspecified

DX 4: R00.0 Tachycardia, unspecified

Plan: Disc with patient and mother at length

Longstanding sxs of 4 months duration, initially cough, progressed to emesis and abdominal pain with weight loss, now overwhelming sxs is fatigue and also has epistaxis but no other sxs of bleeding issues.

Reviewed multiple visits to us and to specialists as well as all diagnostic tests done over the past few months.

Differential dx includes:

1. Infection: doubt acute infection since no fever, but may be "post infectious" syndrome. Will place PPD due to weight loss and cough. recheck here in 2-3 days for PPD reading

2. Cardiac: HR and BP now c/w POTS. Doubt POTS from onset but could be autonomic dysfunction as secondary diagnoses related to viral illness or other stressor

Doubt cardiomyopathy with normal cardiac exam and normal size/shape of heart on CXR but referred to adult cardiology for eval at this point (Gave names/numbers of cardiology groups including Sangrigoli, Smith, Weiman and others). Mom to call us if can't get appt in the next few weeks

3. GI: majority of diagnoses ruled out. GI was going to start eval for gastroparesis, but will hold off until cardiac eval. Gastroparesis can be part of POTS

4. Endocrine: will check TFTs for thyroid dysfunction. No evidence of Addison's, DM or other endocrinologic abnormality

5. Renal: had slightly elevated creatinine on labs done a few months ago. Will repeat chemistries, but doubt that is answer without hypertension or change in urine of any kind

6. Pulmonary: cough resolving and pretty much ruled out be allergist eval

7. Hematology: epistaxis started when he started vomiting often. Disc valsava can lead to nosebleeds. Some crusted blood Keisselbach's triangle and advised to use topical emollients for healing> no evidence of other bleeding (no bruising, gum bleeding, blood in urine or stool) and no HSM or pallor. CBC included in labs ordered

For now, no restrictions on activities: patient advised to do what he can based on how he feels. Gave some baseline POTS advice such as doubling fluid intake, increase salt, avoid laying supine midday when fatigued. Asked him to review POTS information prior to seeing cardiologist and be prepared to discuss sxs

Repeat labs to include: CBC, CRP, Chem complete, TFTs, Vitamin D level: phone f/u when back

recheck in office depending on labs and cardiology eval

The OP coding calculator always defaults to the minimal level for Complexity of MDM, for the reasons outlined in coding calculator documentation. This section does **not** by default show up on the audit note. If the user does not edit the MDM on the coding calculator, and leaves it at the minimal levels, this information will just be omitted from the note/audit note so as not to cause conflicting information.

Complexity of Medical Decision Making			
Diagnoses:	Data review:	Complications:	MDM summary:
<input checked="" type="radio"/> Minimal	<input checked="" type="radio"/> Minimal or none	<input checked="" type="radio"/> Minimal	<input checked="" type="radio"/> Straightforward
<input type="radio"/> Limited	<input type="radio"/> Limited	<input type="radio"/> Low	<input type="radio"/> Low Complexity
<input type="radio"/> Multiple	<input type="radio"/> Multiple	<input type="radio"/> Moderate	<input type="radio"/> Moderate Complexity
<input type="radio"/> Extensive	<input type="radio"/> Extensive	<input type="radio"/> High	<input type="radio"/> High Complexity

If the user **does** want the details of this information to display in the audit note, regardless of level documented, the user must check the "Coding count override" box.

Diagnostic/Procedure Codes Coding Decision Support Coding Statistics

Type of visit:

☒ Established ☐ Inpatient ☐ Consult
☐ New patient ☐ Telephone ☐ Online

Documentation supports: 99213

Key component(s): 2 of 3

Coding count override: ☒

Apply Recalc

If higher levels are chosen by the user, it is important to note that the *thought process* must be supported in the body of the note whenever MDM factors into the decision to choose a coding level.

To review, If the user choses to document a higher level of MDM in the coding calculator **and** the coding override box is checked, then that information is revealed in the audit note:

Care Plans Prior Notes Templates **Coding Decision Support** Coding Statistics

Type of visit:

☒ Established ☐ Inpatient ☐ Consult
☐ New patient ☐ Telephone ☐ Online

Documentation supports: 99215

Key component(s): 2 of 3

Coding count override: ☒

Apply Recalc

History Documentation

HPI elements:

☐ 1-3
☒ 4 or more

ROS categories:

☐ 1
☐ 2-9
☒ 10 or more

Pert sections:

☒ Medical
☒ Family
☒ Social

History summary:

☐ Problem Focused
☐ Expanded Problem Focused
☐ Detailed
☒ Comprehensive

Exam Documentation

Exam elements:

☐ 1-5
☐ 6-11
☒ 12 +
☐ 2+ on 9 systems

Vital signs measured: 6

(3 + count as 1 element)

Exam summary:

☐ Problem Focused
☐ Expanded Problem Focused
☒ Detailed
☐ Comprehensive

Complexity of Medical Decision Making

Diagnoses:

☐ Minimal
☐ Limited
☐ Multiple
☒ Extensive

Data review:

☐ Minimal or none
☐ Limited
☒ Multiple
☐ Extensive

Complications:

☐ Minimal
☐ Low
☐ Moderate
☒ High

MDM summary:

☐ Straightforward
☐ Low Complexity
☐ Moderate Complexity
☒ High Complexity

Counseling/Coordination of Care (Time-Dominated Visit)

☒ Time not a key factor. ☐ Counseling/COC > 50% of visit

Visit length (minutes): 0

Plan

Discussed diagnosis/concerns with patient/family
If provided/available discussed completed/scored/reviewed
Discussed legal implications/regulations of confidentiality
No suicidal thoughts or ideations at present but discussed
Discussed consideration to psychologist/counselor involvement
Discussed when/if referral to psychiatrist is warranted and
Disc considerations to appropriate therapies including co
Suggested or agreed to following treatment modalities:
Educational information provided to patient/family regarding
Community and web-based resources provided to patient
Again stressed need to contact office immediately if any
Recheck in office:

Coding/Audit Support

Note started: 02/02/2016 09:01 AM

HPI elements: 4 or more

ROS categories: 10 or more

Exam elements: 12 or more

MDM differential diagnoses: Extensive

MDM data reviewed: Multiple

MDM risk of complications: High

Counseling: Time not a key factor.

*Manual coding overrides were applied to this encounter.

Relying strictly on the Coding Calculator to document HPI elements:

Counting of elements for HPI is complex and can be confusing. There are multiple areas that can qualify as elements of an HPI and not all of them are available nor pertinent to every visit. It is important that the user understand what constitutes countable HPI elements according to this rubric and use OP's coding calculator as a *guide*. If the user documents additional information in the text section they should manually choose the most appropriate radio button.

HPI Elements: The following eight elements may be used to characterize a specific somatic complaint

- a. Location
- b. Quality
- c. Severity
- d. Duration
- e. Timing
- f. Context
- g. Modifying Factors
- h. Associated Signs and Symptoms

There are two levels of HPI:

1. **Brief HPI:** Requires one to three HPI elements
2. **Extended HPI:** Requires four HPI elements or the status of three chronic problems if using the 1997 E/M guidelines (but not if using the 1995 rules!)

Fever, while important and common in pediatrics, is not its own element. Fever can be an “associated sign and symptom” but then you can’t count any additional associated signs and symptoms you have entered in the text field (all associated signs and symptoms count as one element, including fever if chosen from the pulldown).

In addition, CMS has clear language that HPI can only be entered by the provider seeing the patient.

Only the billing clinician may document the history of the present illness. Unlike the chief complaint, review of systems, and past family medical and social history where a staff member might document part of the history as long as the physician has reviewed it, the history of the present illness must be documented by the billing provider.

To date we have not had auditors request the OP audit log, but they could choose to do that. Best practices suggest users follow the above guidelines and the billing clinician should enter this information and thoughtfully choose whether this is a brief (1-3 elements) or extended (4 or more elements) HPI.

References:

[CMS E/M Services Guide](#)

[E/M University: History of Present Illness](#)

[History of Present Illness: Codapedia](#)

[AAP News Coding Corner: Provider Must Document HPI When Reporting E/M Service](#)