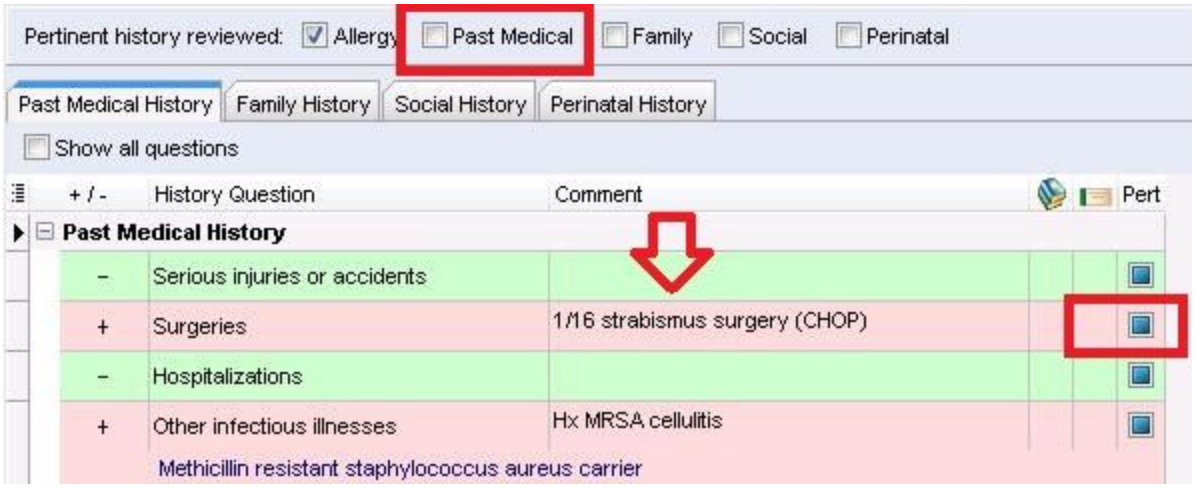
Coding and Documentation Frequent Gotchas

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

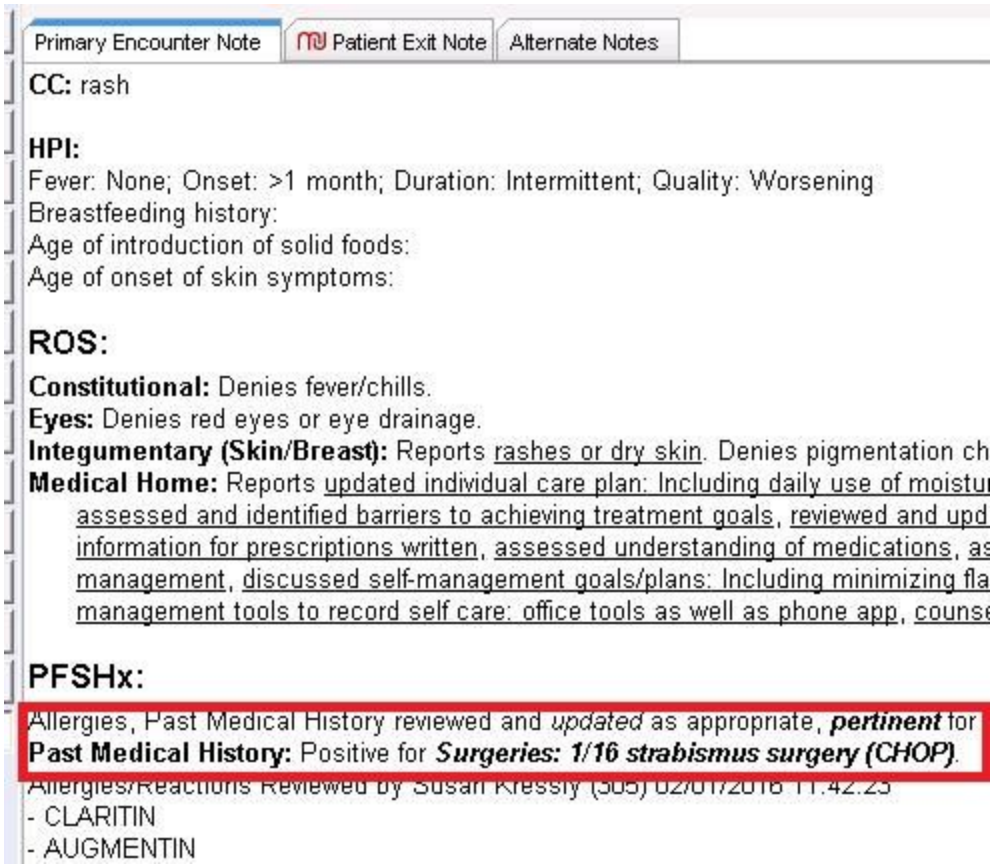
<u>History Information reviewed but not medically pertinent</u>:

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.

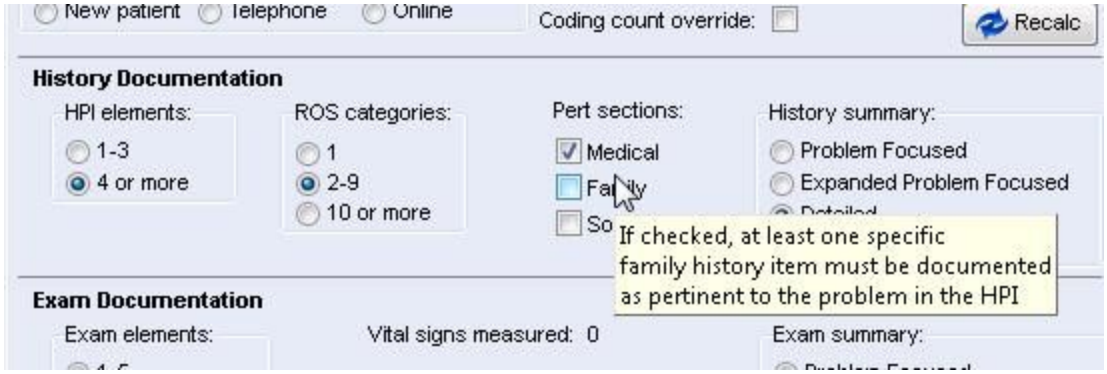
You update the past medical history, but since this is not pertinent to the reason for the visit, you want to make sure that you do not check the box for Past Medical in the “pertinent history reviewed” *nor* check the “pertinent box” to the right of the strabismus box as demonstrated in the screenshot below:
(**Note**: prior versions of OP sometimes “auto-checked” this information if you were documenting new information.)



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



And counted in the coding calculator:

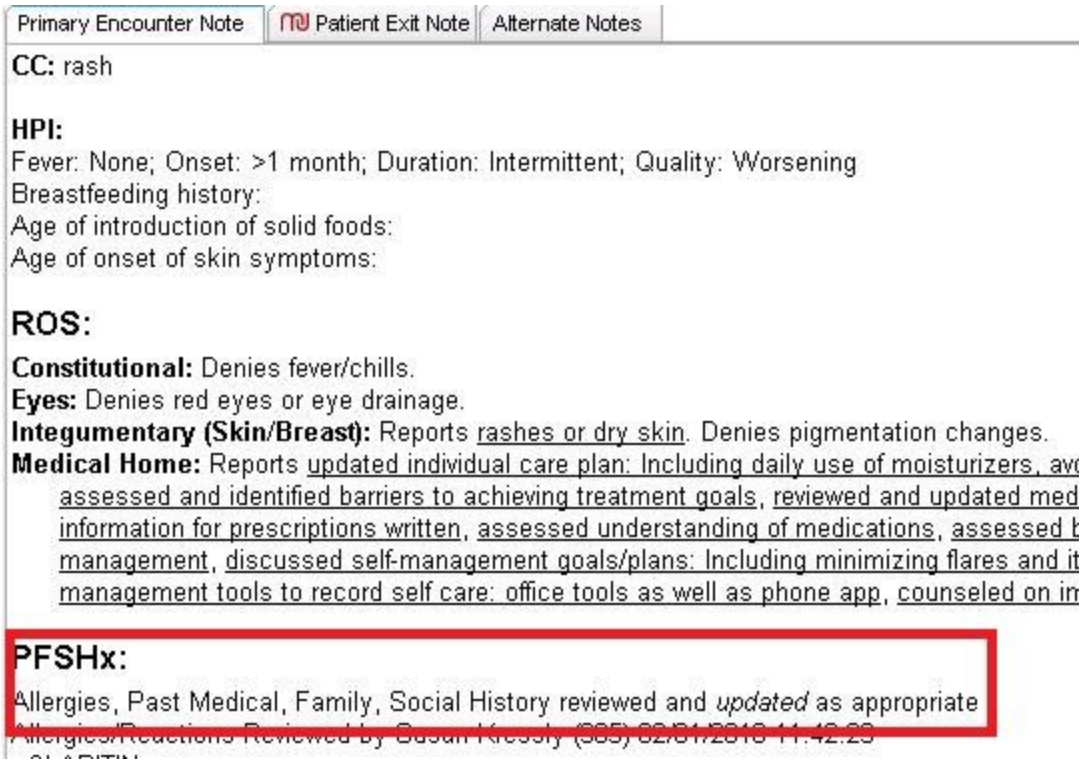


However, an auditor could challenge this coding since the medical history checked is not medically “pertinent” to the reason for the visit.

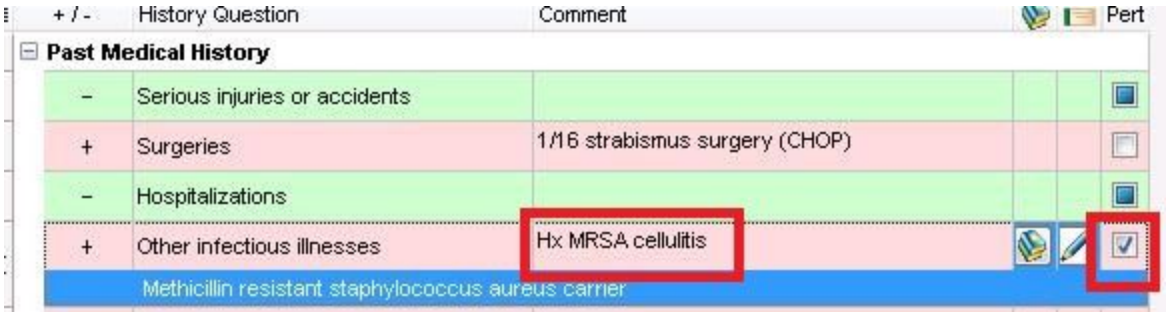
History reviewed and pertinent but insufficient information:

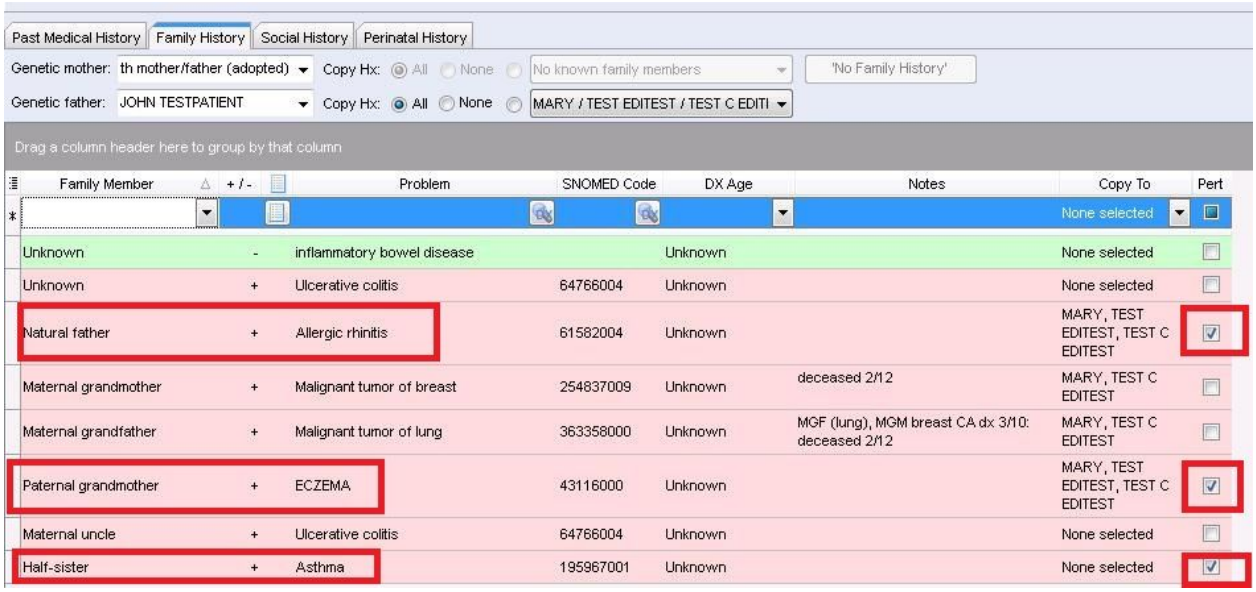
Some auditors/reviewers specifically want documentation of what portions of the history were reviewed and specific information about pertinent/relevant medical information. If your staff or provider simply check history boxes as reviewed, the summary note/audit note will not

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



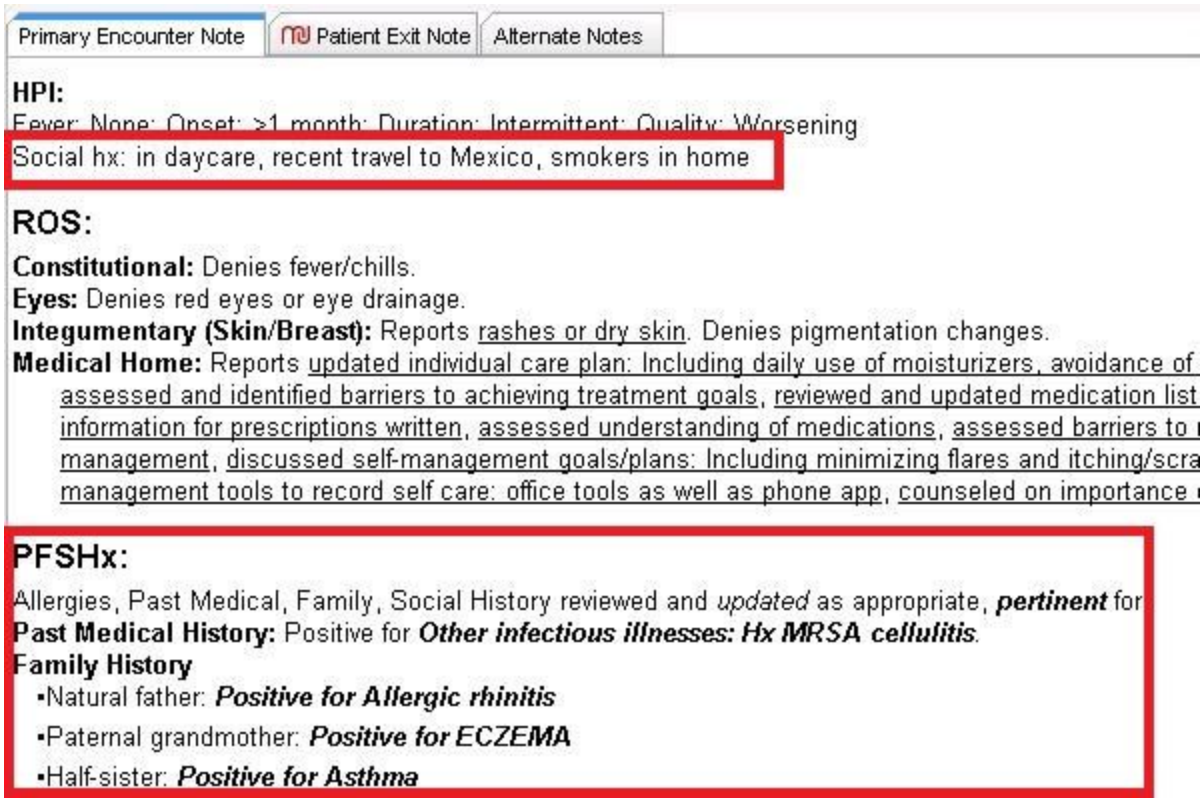
To document pertinent information, it is necessary to choose a pertinent item and check the box:





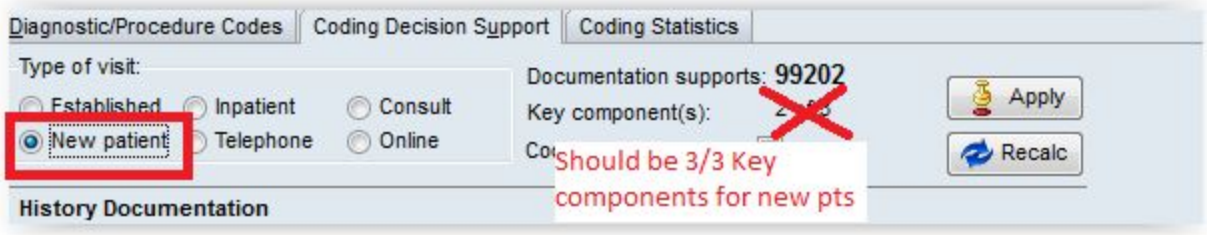
OR document it somewhere else in the note as free text and hand check the pertinent reviewed history section:

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:



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.



Inadequate documentation of Medical Decision Making (MDM) complexity:

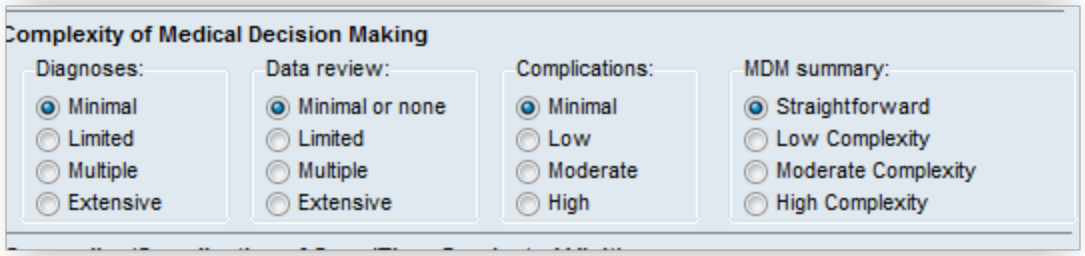
Best practices are always that provider "think out loud" in the note to justify medical decision making including diagnoses, differential diagnoses, information reviewed, and potential complications. Many users document the MDM complexity in the Assessment/Plan section of the visit.

Assessment:

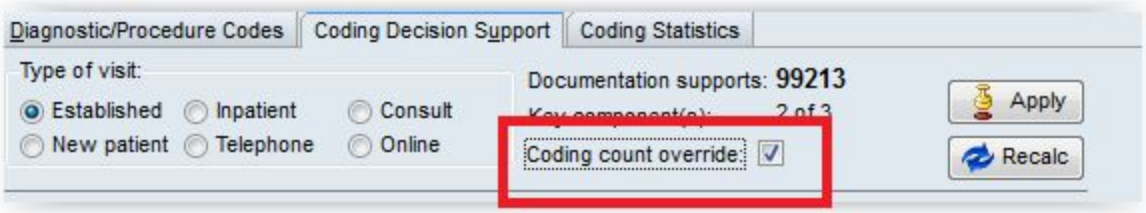
DX 1: R53.83 Fatigue
DX 2: R04.0 Epistaxis
DX 3: R11.10 Vomiting, unspecified
DX 4: R00.0 Tachycardia, unspecified

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 valsalva 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.

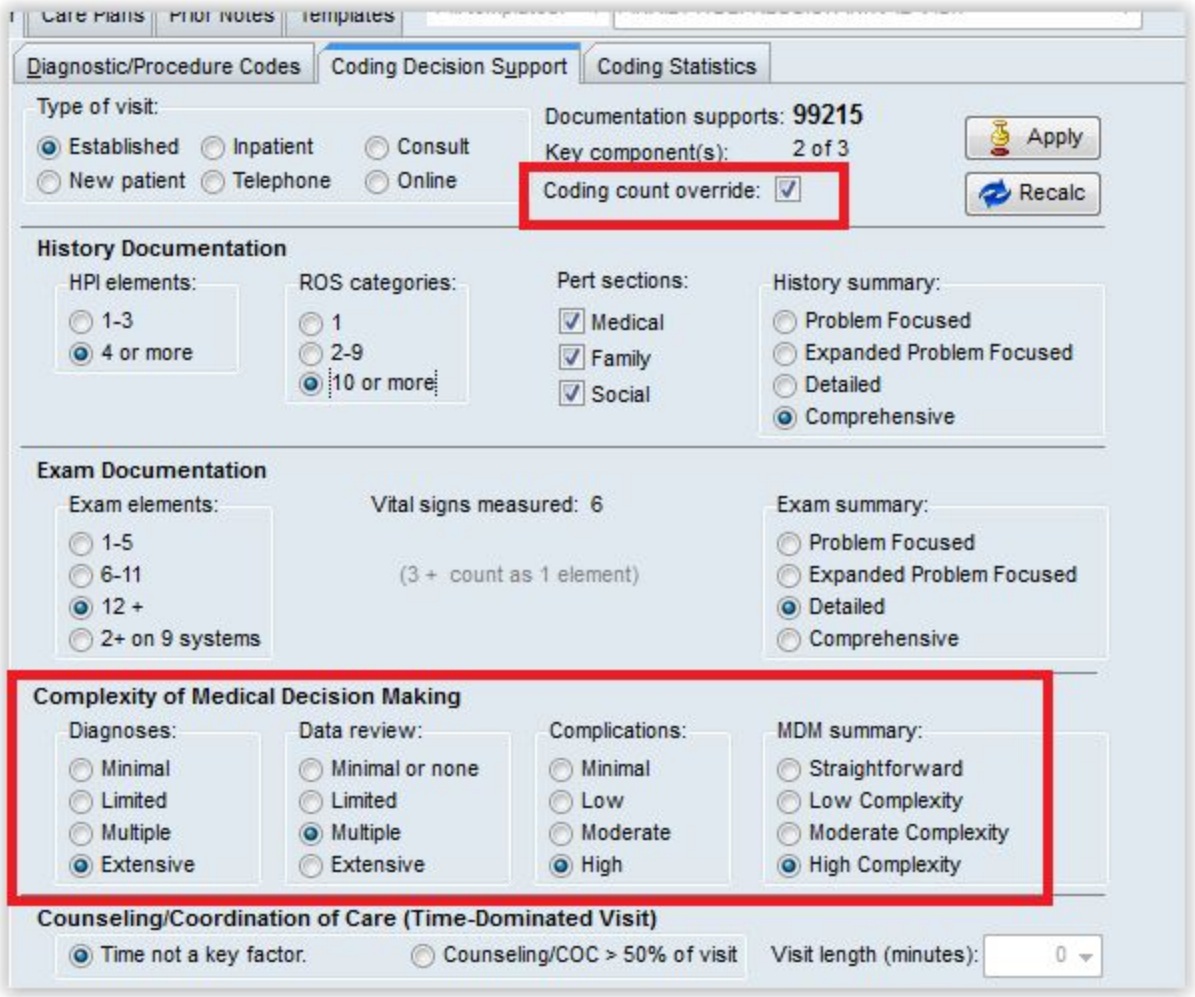


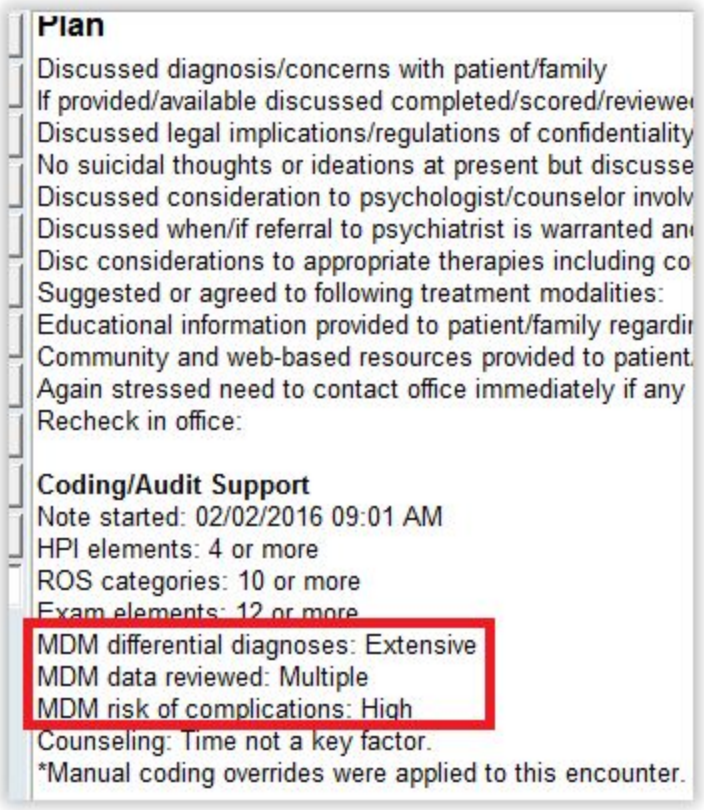
If the user ***does*** want the details of this information to display in the audit note, regardless of level documented, the user must check the “Coding count override” box.



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.

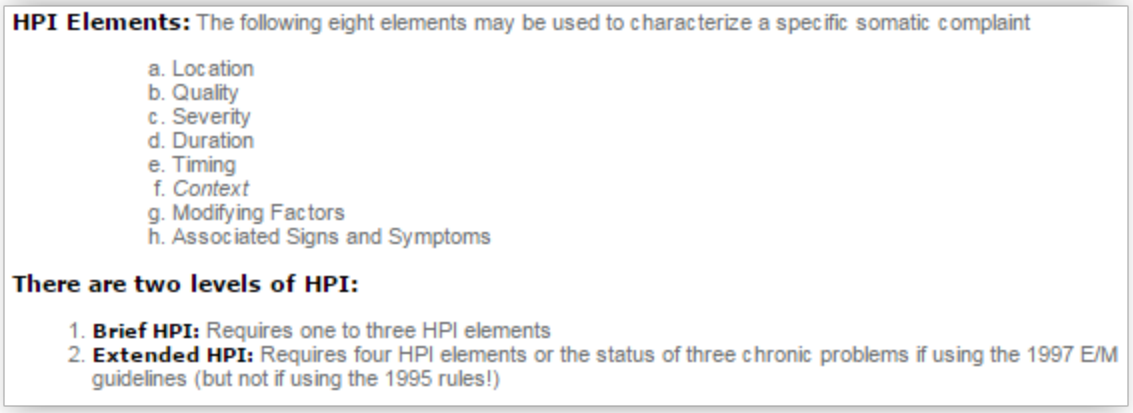
To review, If the user choses to document a higher level of MDM in the coding calculator **and** the coding override box is checked, then that information is revealed in the audit note:





<u>Relying strictly on the Coding Calculator to document HPI elements</u>:

Counting of elements for HPI is complex and can be confusing. There are multiple areas that can quality 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.



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