

If it wasn't done, don't document it: Tackling E&M coding errors in the age of EHRs



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The coder's adage — "If it wasn't documented, it wasn't done!" — has evolved into a different warning: "If it wasn't done, don't document it."

For the past two decades, medical providers have struggled to document and code for their E&M services. As a result, there are an increasing number of errors in claims. And some of these errors — and omissions of information — might be construed as fraud, which is why it's important to review some of the key areas where the most errors occur.

Most codes in the E&M section of the American Medical Association's (AMA) *CPT Manual* describe E&M services with three key components: history, exam and medical decision making. For years, auditors and educators have sent one message to providers: Document more to support your level of service.

Today, EHR systems make it easier for providers to capture this information with templates and the macros tool, which allows you to insert previously saved text using a command, such as "normal shoulder exam," that creates a record that is more complete than medically necessary. In other words, all billed E&M services must be based on activities that are reasonable and necessary for the diagnosis or treatment of illness or injury (SSA 1862(a) (1) (A)). The regulations specify: "Documentation of History, Physical Examinations and Medical Decision Making should not be performed or billed at levels greater than needed for the patient's condition."

The risk is that a code can be selected for the highest level of documentation and not the nature of the presenting problem.

The history of present illness (HPI) must explain why the service is provided. Providers should approach coding the same way they approach treating their patients.

A good rule of thumb is to do what the patient needs, document what you did and bill what you documented.

The HPI describes why the patient is being seen *today*. The Centers for Medicare & Medicaid Services' (CMS) 1995 and 1997 Documentation Guidelines allow statements using the HPI elements (see box) or the status of three or more chronic conditions. The status is not merely a statement of conditions, such as "patient is seen for six months for follow-up on hypertension, obesity and hypercholesterolemia," but should provide details about the treatment ("well-controlled hypertension on metropolol, patient continues with weight management program, a statin drug was prescribed, and total cholesterol is improving").

This information justifies the extent of the review of systems (ROS) history. Each system reviewed should be relevant to the HPI — not simply completing the same list for every patient, regardless of why the patient is seen. Patients who present to the emergency department or for a hospital admission might require a more detailed ROS if they are not known to the provider or if they are elderly or have complicated cases. However, when a healthy patient presents with a wrist sprain, there may not be a reason for a complete 14-system ROS. If there is, the reasons should be documented in the HPI. Providers should not document extensively or use the phrase "all others negative" unless all other systems have actually been queried and it was necessary to do so. Overdocumenting to get to a higher level of billing code is considered fraud.

The same risk occurs with the physical examination. Each body area or organ system reviewed should be medically necessary, and the extent of examination should be justified by the HPI. Auditors are looking for "cloned notes," which show

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that physical examination and normal findings are exactly the same from one date of service to another in a patient's chart, and from one patient to another for the same provider. Examination of body areas and organ systems that are irrelevant and normal cannot count toward the level of service, according to CMS.

Office visit established

Code	Time
99211	5 min
99212	10 min
99213	15 min
99214	25 min
99215	40 min

Office visit new

Code	Time
99201	10 min
99202	20 min
99203	30 min
99204	45 min
99205	60 min

Statements such as "extremities, negative" do not count, as there is no indication of what was examined and why. Findings that are vague, such as "neck, negative," can be problematic. The neck can be examined for several reasons. "Neck, supple" can mean normal range of motion to rule out meningitis or cervical arthritis or supple skin. "Neck, no masses" can mean no lymphadenopathy or thyroid goiter. Cardiovascular examination of the neck may be documented as "neck, no jugular venous (JV) distention or bruits noted and equal carotid pulses." A coder may attribute or count the neck examination to whatever system the findings relate, such as meningitis, thyroid or JV pressure.

The more details the provider documents, the better understanding the reader has about the reason for the examination.

The abuse or overuse of templates becomes obvious when the ROS findings are impossible to believe. For instance, the patient is a 91-year-old male and the template contains this note: "Female GU: Patient denies pregnancy." When this is the same ROS for every patient seen by a provider, it is apparent that the ROS questions are not actually being asked. The cause of this could be poor training for providers, who might not know how to edit and delete irrelevant items from notes in the template. Auditors often see information in the history and exam that contradict HPI documentation. For example, a patient is not a smoker, according to the social history notes, but the HPI describes a nagging cough and cigarette smoking.

Another risk is using templates that refer to information captured on patient history forms without completing the form. A disclaimer that "any items left blank on the form were discussed with the patient and are considered to be negative" should not be used in place of an "all others negative" statement.

EHR templates for history headings, such as medical decision making, can also overstate the complexity of a service by automatically inserting every patient problem as an active diagnosis. The assessment and plan history heading should state the diagnoses addressed at the encounter and should only include chronic diseases or conditions when they are a significant part of the medical decision making process. If the provider uses the guidelines for calculating the type of medical decision-making created by the Marshfield (Wis.) Clinic, only relevant information should be considered.

Time as an element in coding

A high number of coding errors is also reported with time-based services. Many provider visits are spent educating patients

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about their diseases and management of them. In some instances, a patient is seen without a physical examination, a history is taken, and the doctor recommends a procedure. A urologist might recommend a cystoscopy for a better examination of the patient. A gastroenterologist could decide to go ahead with an esophagoscopy or colonoscopy. A gynecologist might perform a colposcopic examination. These examinations should be billed separately, and the findings would not count as part of the physical examination, so there is no double dipping.

How can a provider bill for a visit that does not include an exam? The answer is time. When a provider spends more than 50 percent of a face-to-face encounter on counseling and coordination of care, time can be considered the controlling factor in code selection (see table below). And when the provider assesses time, the total visit time is included. An example of a time-based service is when a patient comes in for follow-up on a diabetes diagnosis, reviews blood work and discusses his or her diet without a physical exam. Another common scenario is a surgeon who sees a patient for a visit and decides to progress to surgery. The phrase “a lengthy discussion” of risks, benefits and postoperative course should remind physicians to document time. Time must be explicitly stated, either in total duration of the visit (45 minutes) or in clock time (12:10 to 12:50). The physician should also document the fact that more than 50 percent of the face-to-face visit was spent on counseling and coordination of care, and the note should summarize the discussion.

An E&M service cannot be billed without time when a provider documents history, assessment and plan but states “exam deferred today.”

The guidelines state that all of the key components must meet or exceed the requirements for the following categories/subcategories:

- Office, new
- Hospital observation services

- Initial hospital care
- Office consultations
- Initial inpatient consultations
- Emergency department services
- Initial nursing facility care
- Domiciliary care, new patient; and home, new patient

Established patient visits must meet or exceed two of the three key components listed. For these code ranges, only two of the three components are used to determine level of service. For encounters where there are only two key components, providers should document the time.

When it comes to practical use, remember to document thoroughly and bill according to those notes. In a harried environment, it is easy to fall back on shortcuts, but those can create more work — and trouble — if they are used incorrectly.

In our next column, we will delve deeper into the correct use of EHRs to effectively and efficiently fast-track coding processes. 🌐

HPI ELEMENTS

- ▶ **LOCATION:** Where in/on the body are the signs/symptoms occurring?
- ▶ **QUALITY:** Adjectives describing the type of symptoms (sharp, dull, throbbing)
- ▶ **SEVERITY:** Scale of 1 to 10, or description of mild, slight, worse
- ▶ **DURATION:** From the onset or starting point of the sign/symptom
- ▶ **TIMING:** Frequency or number of occurrences: nightly, constant, seldom
- ▶ **CONTEXT:** Circumstances causing or surrounding the event of the sign/symptom. For example, anemia in the context of chemotherapy; symptoms associated with activity, such as meals, stress or injury
- ▶ **MODIFYING FACTORS:** Steps patient has taken to alleviate the symptoms; what worsens the symptoms?
- ▶ **ASSOCIATED SIGNS AND SYMPTOMS:** Other signs/symptoms that the patient has when a sign/symptom occurs
- ▶ **LEVEL OF HPI:** Brief, one to three elements; extended, four or more elements