DOCUMENTATION OF MEDICAL NOTES

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- Medical records are legal documents.

- All notes must be legible and complete.
- The auditor will decided if they are legible.

- All services provided are reported to the insurer must relate to medical necessity and appropriateness.

- The CPT and ICD-9 codes reported on the encounter form must be supported by the documentation in the medical record.

What All Documentation Should Include

- Reason for the visit.
- Relevant history, physical exam findings and/or prior diagnostic test results.
- Assessment, clinical impression or diagnosis.
- Plan of Care.
- Date.
- Legible identity of provider.
- Reason for ordering diagnostic and other services should be easily inferred.
- Patients progress, response to and changes/revisions in treatment/diagnosis should be documented.

Audit Triggers

- Frequency of visits:

A stable condition in and of itself does not justify more than 4 visits a year. If there are circumstances that require a greater number of visits, this needs to be reflected on the encounter form.

Audit Triggers

- Excessive Use of 1 Procedure Code

Always using 99213 or 99214 in Family Practice alerts a payer that there is a problem with the provider's reporting.

Audit Triggers

- Inconsistent coding patters among members of the same specialty/same group/same location.

New or Established Patients

- They are a new patient if they NOT been seen at Urgent Care, School-Based Health Center, Elm Park, or on one of the Teams in the last 3 years.
- This does not include Dental or Social Services.

Chief Complaint

- The note must state why the patient is there.
- There may be more than one reason.
- Must state what a follow-up visit is for.
- “Routine” is not a reason for a visit.

First Part of Documentation

1. History of Present Illness
   Review of Systems
   Past, Family and Social History

Second Part of Documentation

- 2. Physical Exam

Third Part of Documentation

3. Presenting Problem to Provider

   Amount and/or Complexity of Data to be reviewed

   Risk of Complications/Morbidity/Mortality

History of Present Illness

There are 8 factors that make up this area.
Each factor may only be counted once, no matter how many times it applies.

1. HPI

LOCATION

Where the problem is on/in the body?

[LLL quadrant, throat, head]

2. HPI

QUALITY

A word that describes the problem.

[Sharp, dull, dry, wet, hot, cold, clammy, burning]

3. HPI

SEVERITY

How is the problem rated?

[Mild, moderate, severe, excruciating, worsening, Pain Scale 4/10]

4. HPI

DURATION

How long do the symptoms last?

[Constant, intermittent, seconds, minutes, hours, days, weeks, months, years]

5. HPI

- TIMING

When did symptoms ?

[One week ago, 3 hours ago]

6. HPI

CONTEXT

What was the patient doing that caused the symptoms?

[Walking, standing, sitting, chewing, after eating]

7. HPI

MODIFYING FACTORS

What has been done to alleviate or worsen the symptoms?

[OTCs, medications, rest, elevation, change in diet]

8. HPI

ASSOCIATED SIGNS AND SYMPTOMS

Conditions that go with the presenting problem.

[Headache, nausea, diarrhea, palpitations]

HPI CODING REQUIREMENTS

- Level 99202, 99212 requires at least 1
- Level 99203, 99213 requires at least 1
- Level 99204, 99214 requires at least 4
- Level 99205, 99215 requires at least 4

OR

You can substitute the status of 3 chronic health conditions for 4 HPI requirements

PAST, FAMILY AND SOCIAL HISTORY

- Past History
  [Illnesses, operations, injuries, treatments, medications, allergies]
- Family History
  [Diseases, which are hereditary, or put the patient at risk]
- Social History
  [Smoking – active or passive, drug use, alcohol use]

CODING REQUIREMENTS FOR PAST, FAMILY AND SOCIAL HISTORY

This section is dependent on knowing if the patient is a new or established patient.

NEW PATIENT

- Level 99202 requires none
- Level 99203 requires none
- Level 99204 requires at least 1
- Level 99205 requires at least 3

ESTABLISHED PATIENT

- Level 99212 requires none
- Level 99213 requires none
- Level 99214 requires at least 1
- Level 99215 requires at least 2

REVIEW OF SYSTEMS

- These are based on questions the provider asks the patient.
- One question from a specific area must be asked to include the system.
- “ROS done” and “All ROS Negative” are inappropriate.
- There are 14 divisions of the Review of Systems

REVIEW OF SYSTEMS

- Constitution [generally feeing of health]
- Eyes
- Ears, Nose, Throat, Mouth
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary

REVIEW OF SYSTEMS (CONT.)

- Musculoskeletal
- Integumentary (and/or Breasts)
- Neurological
- Psychiatric
- Endocrine
- Hematologic/Lymphatic
- Allergic/Immunologic

CODING REQUIREMENTS FOR REVIEW OF SYSTEMS

- Level 99202, 99212 requires none
- Level 99203, 99213 requires at least 1
- Level 99204, 99214 requires at least 2
- Level 99205, 99215 requires at least 10

PHYSICAL EXAM DOCUMENTATION

- The body is described as either a body part of an organ system.
- Both methods can be used for the same note, but only one can be used for a specific exam part [which ever is more advantageous to the provider].

BODY PARTS

- Head (this includes sinuses)
- Neck
- Chest (including Breasts & Axillae)
- Abdomen
- Genitalia (Groin & Buttocks)
- Back & Spine
- Each extremity (up to 4 points in total)

ORGAN SYSTEMS

- Constitution
- Eyes
- Ears, Nose, Mouth, Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Skin
- Neuralgic
- Psychiatric
- Hematologic/Lymphatic/Immunologic
  [lymph nodes notes must be in 2 or more areas]

CODING REQUIREMENTS FOR PHYSICAL EXAM

- Level 99202, 99212 requires at least 1
- Level 99203, 99213 requires at least 2
- Level 99204, 99214 requires at least 5
- Level 99205, 99215 requires at least 9

MEDICAL DECISION MAKING

This is the section that drives coding

There are 3 distinct areas:

- Presenting Problem
- Amount/Complexity that the Problem/s Need
- Risks of Complications/Morbidity/Morality

PRESENTING PROBLEM

- Self-Limiting

  1 point each to a maximum of 2 points

  It would resolve even if they had not seen the provider

PRESENTING PROBLEM

- Established

  1 point if stable or improving, 2 points if worsening

A problem that they have been seen for before. Needs to document if stable, worsening, or improved

PRESENTING PROBLEM

- New to this provider

  3 points if no work-up

  4 points if work-up ordered

CODING REQUIREMENTS MEDICAL DECISION MAKING

- Level 99202, 99212 requires 0-1 point
- Level 99203, 99213 requires 2 points
- Level 99204, 99214 requires 3 points
- Level 99205, 99215 requires 4 points

AMOUNT/COMPLEXITY THAT THE PROBLEM/S NEED

- Order/review lab tests (1 point maximum)
- Order/review radiological tests (1 point maximum)
- Order/review other tests (1 point maximum)
- Discussion of test results with order physician (1 point maximum)
- Decide to obtain old records (1 point maximum)
- Decide to obtain history from someone else not with patient (1 point maximum
- Review and summarize old records, identify who the records came from and what was stated; or get history from a third party other than the person with the patient; or discuss the case with another provider (2 points)
- Visualizing of imaging, tracing, or specimen itself (2 points)

CODING REQUIREMENTS AMOUNT/COMPLEXITY THAT PROBLEM/S NEED

- Level 99202, 99212 requires 0-1
- Level 99203, 99213 requires 2
- Level 99204, 99214 requires 3
- Level 99205, 99215 requires 4

RISK OF COMPLICATIONS/MORBIDITY/ MORTALITY

- Divided into three sections
  - Diagnoses of management problems
  - Diagnostic procedures
  - Treatment of management options

The highest level of risk in any one column determines the overall risk

ICD-9 CODING RULES

- The code must related to the Chief Complaint, HPI, Exam, and Plan.
- You cannot code the conditions managed by another provider (they can be in your note).
- Conditions that are resolved are not billable.
- The order of the codes is important. Put “1” by the most significant code for the visit.
- Recurrent use of “unspecified” codes can trigger an audit.
- The provider is legally responsible.

VISITS WHEN THE MAJORITY OF TIME IS SPENT IN COUNSELING

- If more than 50% of the face to face time is spent in counseling, use the total amount of time to drive the coding for the visit.
- They are also being seen for a medical complaint
- Document the total time of the visit, the time spent in counseling, and the subject discussed.

COUNSELING WITHIN A MEDICAL VISIT

- **New Patients**

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

- **Established Patients**

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

Counseling and Education ONLY Visit

- Based on time.
- New Patients and Established Patients are treated the same.
- There is no presenting physical problem.
- Can be used for New Patients who come to establish.

Codes/Times for Coding/Education Visit

99401	15 minutes
99402	30 minutes
99403	45 minutes
99404	60 minutes

Counseling ICD-9 Codes

- V65.3 Dietary surveillance and counseling
- V65.42 Substance use/abuse
- V65.43 Injury prevention
- V65.44 HIV
- V65.45 STDs
- V65.49 Other specified counseling

Developmental Screening

- All physicals under the age of 21.
- MANDATORY – it will affect our total reimbursement from Medicaid
- Codes are determined by provider type and if they are in need of services or not (if they are currently receiving services, they are considered to be in need).

Codes for Developmental Screening

- Physicians

  No need found 96110-U1

  In need of services 96110-U2

Codes for Developmental Screening

- Nurse Practitioners

No need found 96110-U5

In need of services 96110-U6

Codes for Developmental Screening

- Physician Assistants

No need found 96110-U7

In need of services 96110-U8

Emergency Situations

When a patient is sent to the ER via ambulance, it should be reported as a 99205/99215.

It is not considered an emergency situation when an ambulance is called for transportation issues.

You note must contain the requirements for a level 5 visit, or specifically state that you were unable to obtain the information because of the patient's status.

Obstetrics

- Pregnancy visits are generally billed under the global fee.
- The exception is if they are they for any other reason, then they should be billed as a regular visit, guided by the reason for the visit.

ICD-9 Codes for Pregnancy

- V22.0 Supervision of normal first pregnancy
- V22.1 Supervision of other normal pregnancy
- V22.2 Pregnant state, incidental

Consultations

- This is a type of service provided by a medical provider who advice regarding a specific problem is requires by another provider.
- It is not a transfer of care