DOCUMENTATION OF MEDICAL NOTES
(Based on 1995 Guidelines)

General Principles

Medical records are legal documents.

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

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

The CPT and ICD-9 codes reported on an encounter form should 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.

The reason for ordering diagnostic and other services should be easily inferred.

Patient's 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 other circumstances that require a greater number of visits, these needs to be reflected on the encounter form.

Excessive Use of 1 Procedure Code
> Always using 99213 or 99214 in Family Practice is a problem.

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

Are They a New or Established Patient?

It is important to determine this at the beginning since it will help you determine requirements in your documentation.

They are a new patient if they have <u>not</u> seen a medical provider at Family Health Center in the last 3 years. This could be in Urgent Care, School-Based Health Centers, Elm Park, Webster Square or on a Team. This does not include Dental or Mental Health. If you have a chart with no notation, it is wise to ask the patient, since documentation may not have made it into the chart before you saw the patient.

Chief Complaint:

This is the reason the patient is there to see the provider. There may be more than one reason. If it is for a follow-up visit, it must state the condition that is being followed: i.e., follow-up on asthma, diabetes, rash, etc.

"Routine" is not an appropriate statement.

Parts of Documentation:

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

2. **Physical Exam**

3. **Presenting Problem to Treating Provider**
   Amount and/or Complexity of Data to be Reviewed
   Risk of Complications/Morbidity/Mortality

I. History of Present Illness:

There are 8 factors that can be addressed:

1. Location – where is the problem on/in the body
   [LLL quadrant, throat, head]

2. Quality – a word that describes the problem
   [Sharp, dull, dry, wet, hot, cold, clammy, burning]

3. Severity – how is the problem rated
   [Mild, moderate, severe, excruciating, worsening
   Pain scale (4/10)]

4. Duration - how long do the symptoms last?
   [Constant, intermittent, seconds, minutes, hours, days, weeks, months]

5. Timing – when did symptoms begin?
   [One week ago, 3 hours ago]

6. Context – what was the patient doing that caused the symptoms?
   [Walking, standing, sitting, chewing, after eating]

7. Modifying Factors – what has been done to alleviate or worsen the symptoms?
   [OTCs, medications, rest, elevation, change in diet]

8. Associated Signs and Symptoms – conditions that go with the presenting problem
   [Headache, nausea, diarrhea, palpitations]

   Coding Requirements:

   **Level 99202, 99212 require at least 1
   Level 99203, 99213 require at least 1
   Level 99204, 99214 require at least 4
      (or status of at least 3 chronic health conditions)***
   **Level 99205, 99215 require at least 4
      (or status of at least 3 chronic health conditions)***

If patient is unable to provide the history, document this and the reason they are unable to. This will allow you to consider the maximum number.

*The must be a rational for the reason of the status, such as lab work with specific information or symptom frequency.

Past, Family, and Social History:

Past History:
Patient's past experiences with illnesses, operations, injuries, treatments, medications, or allergies relevant to the condition being treated. (All medications and allergies are relevant.)

Family History:
Diseases which are hereditary, or put the patient at risk.

Social History:
Past or current activities that are appropriate for patient (i.e. smoking - active or passive, drug use, alcohol use).

Coding Requirements:

New Patients
Level 99202 require none
Level 99203 require none
Level 99204 require at least 1
Level 99205 require at least 3

Established Patients
Level 99212 requires none
Level 99213 requires none
Level 99214 requires at least 1
Level 99215 requires at least 2

If the patient is unable to provide this information, document this fact in the chart and the reason. You will then be able to use the maximum number available.

Review of Systems:

These are based on questions that the provider asks the patient.

At least one item must come from a specific area for that area to be included.

If patient's condition prevents them from doing a review of system (a physical or mental condition), it should be stated so and then Review of Systems will receive the necessary credit.

This generally starts with "Patient denies…" or "Patient states…."

1. Constitution – general opinion of health
2. Eyes
3. Ears, Nose, Throat, Mouth
4. Cardiovascular
5. Respiratory
6. Gastrointestinal
7. Genitourinary
8. Musculoskeletal
9. Integumentary (and/or Breasts)
10. Neurological
11. Psychiatric
12. Endocrine
13. Hematologic/Lymphatic
14. Allergic/Immunologic

Statements such as "ROS done" or All ROS negative" are inappropriate.

Coding Requirements:

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

II. Physical Exam

Organ Systems and Body Parts are both included in the physical exam.

An item can be included in either an Organ System or a Body Part, but the same item cannot be in both. One point is achieved when a System or Part is identified. Each System or Part is counted only once.

Body Parts:

1.   Head (this includes sinuses)
2.   Neck
3.   Chest (including Breasts & Axillae)
4.   Abdomen
5.   Genitalia (Groin & Buttocks)
6.   Back & Spine
7.   Each Extremity (each extremity is counted once - up to 4 points in total)

Organ Systems:

1.   Constitutional
> One vital sign and general appearance of patient
> (Vitals taken by a MA should be dictated into the note. This acknowledges that they were reviewed.)
2.   Eyes
> conjunctivae & lids; PERRLA, EOMs intact; optic discs
3.   Ears, Nose, Mouth, Throat
> external ears and nose; ears and TM's; hearing; nasal mucosa; septum & turbinates; lips, teeth, & gums; oropharynx
4.   Cardiovascular
> palpitation of heart; auscultation; carotids; abdominal aorta; femoral pulses; pedal pulses; extremities for edema &/or varicosities
5.   Respiratory
> respiratory effort; percussion; palpation; auscultation
6.   Gastrointestinal
> masses, tenderness; liver & spleen; hernia; anus, perineum & rectum; occult test
7.   Genitourinary
> Male:
>> scrotal contents; penis; prostate gland
> Female:
>> external genitalia; urethra; bladder; cervix; uterus; adnexa/parametric

8.   Musculoskeletal

        gait & station; digit & nails; joints, bones, muscles of at least 1 area
        Extremities: left upper, right upper, left lower; tight lower, head, neck,
        spine, ribs, pelvis
        (exam should include inspection/palpation, ROM, stability, strength, tone)

9.   Skin

        inspection; palpation

10. Neuralgic

        cranial nerves; reflexes; sensation

11. Psychiatric

        Judgment & insight; orientation of time, place & person; memory; mood
        & affect

12. Hematologic/Lymphatic/Immunologic

        lymph nodes in 2 or more areas: neck, axillary, groin, other

        Coding Requirements:

        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

III. Medical Decision Making:

This is the section of your note that drives your level of coding.

Presenting Problem:

It is necessary to determine if the problem is:

> Self-limiting (1 point each, to a maximum of 2 points)
> > It would resolve even if they had not seen the provider
>
> Established (1 point if stable or improving, 2 points if worsening)
> > A problem that they have been seen for before
> > Need to document if stable, worsening, or improved
>
> New to this provider (3 points if no work-up, 4 points if work-up ordered)
> > Determine if any work-up needs to be done

When listing a diagnosis on your note, it is best to list the status next to it. If you are listing a diagnosis that is managed by another provider, state that fact, and do not code it on your encounter form.

Examples:
> Diabetes – uncontrolled – improving
> Asthma, Childhood – stable
> Chronic low back pain - worsening

> ### Coding Requirements:
>
> > **Level 99202, 99212 requires 0 or 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)
[Must be stated as to which lab tests or the results, if known, acknowledged as to normal or abnormal.]

Order/Review radiological tests (1 point maximum)
[Must be stated as to which tests or the results acknowledged as to the results.]

Order/Review other tests (1 point maximum)
[Must state what tests ordered or if reviewing, what the results were and how they impact the patient.]

Discussion of test results with ordering physician (1 point maximum)
[The name of the physician, the test ordered, and the results must be acknowledged.]

Decide to obtain old records (1 point maximum)
[Chart must note this and from where.]

Decide to obtain history from someone else not with patient (1 point maximum)
[Other person must be identified and what history obtained.]

Review and summarize old records, Identify who the records came from and what was stated; or Get history from a third party other than a person with the patient; or discuss the case with another provider (2 points)

Visualizing of image, tracing, or specimen itself (2 points)
[Not a simple review of a written report. Example would be EKG, ultrasound, etc.]

Coding Requirements

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

Risk of Complications/Morbidity/Mortality:

New	99201**	99202	99203	99204	99205
Established	99211	99212	99213	99214	99215
Diagnoses or Management Problems		One Self-limited or minor problem	Two or more self-limited or minor problems One stable chronic condition Acute uncomplicated illness (e.g., allergic rhinitis, simple sprain)	One or more chronic illnesses with complications Two or more stable chronic illnesses Undiagnosed new problem w/ uncertain prognoses Acute illness with systemic symptoms Acute complicated injury	One or more chronic illness with severe complications Acute or chronic illness or injury that is life or limb threatening Abrupt change in neurologic status
Diagnostic Procedures		Lab X-ray EKG UA Ultrasound, etc Venipuncture KOH.	Physiologic tests not under stress Pulmonary Function Barium enema Arterial puncture Skin biopsies	Physiologic tests under stress - cardiac stress test Diagnostic endoscopies with no risk factors Deep needle or incisional biopsy Obtained fluid from body Cardiovascular imaging with contrast	Cardiovascular imaging with contrast Invasive diagnostic tests Cardiac electrophysiological tests Diagnostic endoscopies w/ identified risk factors Discography
Treatment of Management Options		Rest Gargles Elastic bandages Dressings	OTCs Minor surgery w/ no identified risk factors PT OT IVs without additives	Minor surgery with risk factors Elective major surgery - no risk factors Prescription drug management IV fluids with additives Closed fracture or dislocation treatment w/o manipulation Therapeutic nuclear medicine	Elective surgery with identified risk factors Emergency major surgery Parenteral controlled substances Drug treatment requiring intensive monitoring Decisions not to resuscitate or de-escalate care because of poor prognosis

** For a new patient 99201, use the requirements for a new patient 99202

Coding Requirements:

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

If there is not an item in documented in each one of the Presenting Problem, Amount/Complexity of Data, and Risk of Complications/Morbidity/Mortality you, are not eligible for a level beyond 99202.

ICD-9 Coding Rules For Encounter Forms:

The ICD-9 code used must relate to the Chief Complaint, History of Present Illness, Exam and Plan.

You cannot use the conditions that are being managed by another provider (i.e., sleep apnea.) It is permissible to list this in your Assessment and Plan in your note, but billing them is considered fraud since you are not managing them.

Conditions that are resolved are not billable.

The order that ICD-9 codes are placed is important in computerized billing.

A number "1" needs to be placed by the code that most reflects the reason for the visit.

The recurrent use of "unspecified" codes may lead to an audit.

The provider is legally responsible for the ICD-9 codes that are submitted on the encounter form.

Billing For Visits When the Majority of the Visit is Spent Counseling:

If more than 50% of the time of the visit is spent in counseling or education, then you are able to bill according to the amount of time spent face-to-face with the patient. These are for patients that have a medical problem to begin with.

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.

Documentation requires that you list the total time of the visit, the time spent in counseling, and the subject discussed. Time can over-ride all other requirements.

Counseling ICD-9 Codes (These would be used secondary to the medical condition being treated.)

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V65.3      Dietary surveillance and counseling
           (For this code there must be a problem also
           listed such as obesity, underweight, diabetes)
V65.43     Substance use/abuse (tobacco, drugs)
           (The code for the specific drug abuse should
           be listed, i.e. 305.1 tobacco abuse)
V65.43     Injury prevention
V65.44     HIV
V65.45     STDs
V65.49     Other specified counseling
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Billing For Visits When Counseling/Education is the Reason for the Visit

The same code is used for a New Patient or an Established Patient.

99401	15 min.
99402	30 min.
99403	45 min.
99404	60 min.

These codes should be used for New Patients who do not present with a problem. The same codes are used for new and established patients. Generally the V codes for counseling are used.

Developmental Screening (Massachusetts Specific):

All children under the age of 21 are mandated to have a developmental screening at their physical.

The codes used to report that is this has been done are divided by the type of provider that sees the patient, and if the child is in need to services or not. If factors are identified, and the child is already receiving service, they still found to be in need of services. The purpose of these codes is to identify how many children in the commonwealth need services. The codes to be used in community health centers are:

Physicians	No need found	96110-U1
	In need of services	96110-U2
Nurse Practitioners	No need found	96110-U5
	In need of services	96110-U6
Physician Assistants	No need found	96110-U7
	In need of services	96110-U8

Emergency Situations

When a patient is transferred to a hospital via ambulance, and the purpose is because the patient's condition is serious and time is important, it should be reported as a 99215. The rational for the ambulance transfer must be documented. If you have unable to get a complete history and/or Review of Systems, it should be noted why you were unable to get this. This is not to be used in situations where transportation is needed for non-life-threatening situations.

Obstetrics

Pregnancy management is generally billed under a global fee structure. The exception is when there is a problem (pregnancy related or not) that goes outside the course of a routine visit (not a minor problem). In that case, the global code is not billed and a standard Evaluation/Management visit code is used (99212, 99213, 99214, or 99215).

ICD-9 Codes for Pregnancy

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

If a problem is found that not directly related to the pregnancy (asthma, strep throat, etc.), an Evaluation/Management code should be used and the ICD-9 for the problem should be listed first and then followed by V22.2 Pregnancy state, incidental.

Consultations

A consultation is a type of service provided by a medical provider whose advice regarding a specific problem is requested by another provider. It can be requested by another member of your group who has special expertise (such as ADHD). It is not a transfer of care. It cannot be requested directly by the patient or family member.

Four requirements:
1. There must be a request. The person receiving the request should state who made the request.
2. There must be a statement as to the reason for the request.
3. The service must be provided
4. A written report must be sent to the referring physician. Internally, the note is sufficient.

CPT Coding (There is no difference between a new or established patient)

99241 (requirements of a 99201 visit)
99242 (requirements of a 99202 visit)
99243 (requirements of a 99203 visit)
99244 (requirements of a 99204 visit)
00245 (requirements of a 99205 visit)

Coding based on time of the visit

If more than 50% of the face to face time of the visit is spent in counseling, time may determine the level of the visit. The codes below are for the total time of the visit.

99241   15 minutes
99242   30 minutes
99243   40 minutes
99244   60 minutes
99245   80 minutes

ICD-9 Coding Consultations

There are no specific does for a consultation. They should be coded as to the problem that the consultation was requested for. Do not use preventive health codes (V70.0, etc.)

For pre-op exams this the ICD-9 codes in this order:

V72.83   Other specified pre-operative exam
XXXXX   The condition for which the operation is necessary
XXXXX   Any other diagnoses that came up during the exam

Resident Coding

Residents are restricted to the following CPT codes: 99201, 99202, 99212, 99203 or 99213 **UNLESS** the supervising physician performs, or is physically present, during the key or critical portions of the service provided. This must be documented in the note by the supervising physician. That means, for a resident to billing a level 4 or 5, the supervising physician must physically exam the patient. While it may seem easier to only bill a level 2 or 3, the resident, and FHCW, is telling a third party payer that the resident saw no complex patients.

For a resident to bill according to time, the supervising physician must be present for the entire time spent in counseling.