

Principals of Documentation

What is documentation and why is it important?

“Medical record documentation is required to record pertinent facts, findings and observations about an individual’s health history including past and present illnesses, examinations, tests, treatments and outcomes. The medical record chronologically documents the care of the patient and is an important element contributing to high quality care. The medical record facilitates:

- The ability of the physician and other healthcare professionals to evaluate and plan the patient’s immediate treatment, and to monitor his/her healthcare over time
- Communication and continuity of care among physicians and other healthcare professionals involved in the patient’s care
- Accurate and timely claims review and payment
- Appropriate utilization review and quality of care evaluations
- Collection of data that may be useful for research and education”

(Excerpt from the 1995 Documentation Guidelines for Evaluation and Management Services)

ICD-10 and Documentation

With the implementation of ICD-10 in October 2015, thorough documentation will be a key factor in selecting the appropriate diagnosis and CPT/HCPCS codes. Per HRS, a health information vendor who has performed extensive analysis on ICD-10 coding and documentation, identified 7 areas of weakness in documentation when assigning an ICD-10 diagnosis code:

1. Disease type is not indicated
2. Exact details pertaining to diseases are not mentioned
3. Missing documentation
4. Specific location of services (if relevant) is not identified
5. Stages of diseases are missing
6. Right/Left sides are not identified
7. Documentation for combination codes is not accurate

In addition, physicians are not linking diagnoses to plan of care or specifically detailing their concerns for risk and adverse effects if a patient does not have specific treatment. Many physicians document for other physicians. The medical record should tell the story about the patient’s condition and plan of care. The story should be clear, specific and written in language that most non-physicians can understand. Other documentation problems include copying a (statement) exactly from one record to another. This is easy to do with electronic health records and must be monitored closely. Each entry must be unique to that patient. Documentation must support medical necessity for the diagnosis being treated for a patient’s medical condition. Services provided for the convenience of the patient, provider or supplier may not meet medical necessity. Physicians must document using their clinical judgment and make decisions based on the complexity of the care.

Signature Requirements

Services rendered to a patient must be ordered by an authorized provider and must comply with the following signature requirements as stated in the Medicare Learning Network's publication "Complying with Medicare Signature Requirements":

1. Services that are provided or ordered must be authenticated by the ordering practitioner with a valid signature and date.
2. Signatures must be legible. A signature log or attestation statement may be used to identify an illegible signature.
3. Signatures cannot be signed late. If signature on order or medical record is missing, submit an attestation statement from the author of the medical record.
4. If an order for a test(s) is unsigned, it may be supported by the progress notes if intent to order test(s) is documented. Progress notes must specify what test(s) are being ordered.
5. If signature is missing from order and the intent is not derived from the progress notes, the unsigned order will be treated as though it was not received.
6. Service(s) must be reasonable and necessary
7. Medical records must be complete and legible. If you cannot read it, it was not performed.
8. Amendments, corrections or addenda must be clearly identified and dated. When correcting a paper medical record, a single line strike through so that the original content is still readable is permitted. For Electronic Health Records, a reliable means to clearly identify the original content and modified content, date and authorship is required.

Evaluation and Management (E & M) Documentation

Evaluation and Management (E/M) service guidelines are in the CPT-4 manual at the beginning of the E/M section. There are several categories of E/M codes based on place of service and type of patient (new or established). Each category is further defined by the level of E/M. "The levels of E/M services encompass the wide variations in skill, effort, time, responsibility and medical knowledge required for the prevention or diagnosis and treatment of illness or injury and the promotion of optimal health." – (Excerpt from the 2015 E/M guidelines in the CPT-4 manual)

Medicare publishes an Evaluation and Management Services Guide that includes more detail in selecting an E/M level and provides two variations of guidelines: 1995 guidelines and 1997 guidelines. The 1997 guidelines are more detailed than the 1995 guidelines. There are specific differences in documenting the History of Present Illness and the Physical Exam. Providers should consistently use one version for their guidelines.

E/M documentation includes seven components:

1. History
2. Examination
3. Medical decision making
4. Counseling
5. Coordination of Care

6. Nature of presenting problem
7. Time

The first three components, History, Examination and Medical decision making are key components used to select the level of E/M code. The other components contribute to selecting an E/M level by providing more detail about the service and medical decision making. If a provider spends more than 50% of their time counseling and coordinating care with patient and/or family face to face, then time shall be considered the key or controlling factor to qualify for a particular level of E/M service.

Documentation of History

Accurately recording a patient’s history is an important part in selecting the appropriate E/M level. There are four key elements that comprise a patient’s history:

- a. Chief Complaint (CC) – reason for encounter
- b. History of Present Illness (HPI) – development of the patient’s current problem
- c. Review of Systems (ROS) – review of body systems directly related to problem
- d. Past Family and/or Social History (PFSH) –related to illness and disease

History of Present Illness, Review of Systems and Past Family and/or Social History are defined further by the level of detail documented. This level of detail is dependent on clinical judgment and the chief complaint. This detail is used to assist providers in choosing the “Type of History”. This detail is covered in the E/M Guidelines found on the CMS website. See chart below:

Type of History	Chief Complaint	HPI	ROS	PFSH
Problem Focused	Required	Brief	N/A	N/A
Expanded Problem Focused	Required	Brief	Problem Pertinent	N/A
Detailed	Required	Extended	Extended	Pertinent
Comprehensive	Required	Extended	Complete	Complete

Documentation of Examination

A provider examines the body areas and organ system(s) that are identified in the history of present illness. There are four Examination types:

- a. Problem Focused – limited exam of the problem area
- b. Expanded Problem Focused – exam of problem area and other symptomatic organ systems
- c. Detailed – exam of problem area and other symptomatic organ systems (multiple systems)
- d. Comprehensive – complete exam of organ system or multisystem exam

1995 Guidelines are not as specific as the 1997 Guidelines. The 1997 Guidelines have specific details about reviewing key body areas and organ systems. Both guidelines recommend that specific

abnormal and relevant negative findings of the affected or symptomatic body area(s) or organ system(s) should be documented in detail as should any findings for asymptomatic body area(s) or organ system(s).

Documentation of Medical Decision Making

Medical Decision Making is the thought process conducted by a physician using his/her training, experience and expertise to determine what the problem is and how best to treat the condition. The following elements contribute to medical decision making:

- a. The number of possible diagnoses and management options
- b. The quantify of medical records that must be reviewed
- c. The number of tests that should be ordered
- d. The risk of complications, the rate of sickness(morbidity) or the risk of death (mortality)
- e. Impact of condition on patient's health
- f. Severity of presenting problem

There are four categories for medical decision making based on the elements listed above:

- a. Straightforward – minimal decision making required – zero to one element above
- b. Low Complexity – decision making includes two to three of the elements above
- c. Moderate Complexity – Several of the elements above
- d. High Complexity – Many of the elements above

To assign an E/M level code, read the specific instructions in the CPT-4 manual to determine the number of elements required to assign the level. Many E/M codes require all three elements to select the code (History, Examination and Medical Decision Making) or two out of the three elements. The code selection is based on meeting or exceeding the levels of the key components.

1. Check code description to determine whether 2 or 3 elements must be met
2. Review the documentation and match it to the level descriptions for each component
3. Determine the highest level met (equal to or more than the requirements)
4. Compare the levels of each key component and choose the highest level of code for which all key components have been met.

Example:

Setting: Office Visit (three of three components must be met)

Chief Complaint: New patient presents with runny nose, coughing and headache

HPI- No fever, No meds, No allergies

PFSH – Family history Asthma (mother), COPD & Lung Cancer (Grandfather), Patient smokes ½ pack Per day but is trying to quit.

ROS – BP 120/86, R-18, P-80, Eyes- inspects conjunctivae/lids, EAC/TMs inspected, Nasal mucosa/turbinates, Neck – no masses, Lungs – CTAB, good resp effort, Cardio-CTA.

MDM – Sinusitis, RX Given Z-Pak, Information on smoking cessation given

History – Expanded Problem Focus
Exam – Expanded Problem Focus
MDM – Moderate

CPT – Select 99202 – This code requires an expanded problem focus history and exam but a straightforward decision making. The history and exam meet the requirements for this code but the medical decision making exceeds this code selection. Therefore this is the appropriate level. In order to use a higher code for moderate decision making, the history and examination would have to be comprehensive.

Good documentation takes effort but is very important to care for the patient appropriately and to ensure the physician receives adequate reimbursement and safeguards against audits and legal issues. There are many resources to learn about documentation improvement. Please visit the websites of these organizations to search for more information: CMS, AAPC, AHIMA, AMA and organizations for certain specialties.