Dermatology Coding Alert

E/M Coding: 'Follow-Up' Is Not A Sufficient Chief Complaint

Improve Your E/M Payment Odds With These 5 Quick Tips

Most practices report E/M codes every single day, but when you're coding in a routine way, you might actually be in a coding rut. Ensure that you are submitting E/M services properly so you won't spend time chasing denials or re-sending missing documentation.

Check out the following five tips shared during the recent webinar, "E/M: Introducing the Guidelines," presented on Jan. 18 by Palmetto GBA, a Part B MAC in seven states.

1. Avoid Writing the Same Thing for Every Patient. Although you might think of "cloned documentation" as only existing when using electronic health records (EHRs) are utilized, the truth is that even paper records can be considered "cloned" if they are all worded exactly alike.

"Whether the cloned documentation is handwritten, the result of a pre-printed template, or use electronic health records, cloning of documentation will be considered misrepresentation of the medical necessity requirement for coverage of services," said **Carrie Weiss**, senior provider education consultant with Palmetto, during the call.

Even if you see seven patients with the flu on the same date of service, they won't all have the same history, symptoms, treatment recommendation, or prognosis, so copying documentation from one patient to the next is inappropriate. The notes should be tailored to each patient's individual case.

2. Provider Signatures Must Be Legible. Practitioners who are signing documentation by hand should ensure that they include both their first and last names, and that the signature should be legible. In addition, Weiss said, Palmetto recommends that practitioners include their credentials (such as MD, DO, PA, etc.) after their signature.

If a signature is illegible, auditors will use a signature log or attestation statement to determine who authored a medical record entry, but if a signature is missing from an order for other services, the order will be disregarded as if it didn't exist.

3. Services Performed by Ancillary Staff Members Must Be Signed by The Billing Provider. In situations when ancillary staff members perform a service and write documentation, the record must be signed by the practitioner who is billing for the service.

For instance: "If an injection for B12 was provided in the office, whoever was covering for the incident-to or providing that supervision would need to sign that documentation," Weiss said.

4. Don't Mix and Match 1995 and 1997 Guidelines During the Same Visit. Most coders are familiar with both sets of Medicare guidelines when selecting an E/M code, but what some practices don't know is that you can't choose from both sets of guidelines a la carte during the same patient encounter.

"You cannot interchange the two guidelines," Weiss said. "So once you start out using a set of guidelines, you must continue using that set of guidelines. That doesn't mean that at the next visit you can't use the other set of guidelines, but per encounter, you must stick to one," she said.

5. "Follow-Up" Is Not A Sufficient Chief Complaint. All E/M documentation must include a chief complaint, but what your physician lists as the chief complaint may not fit your MAC's requirements.

"The chief complaint is a concise statement that describes the symptom, problem, condition, diagnosis, or reason for the

E/M encounter," Weiss said. "It is typically stated in the patient's own words. An example would be a sore throat, or chest pain. Just stating 'follow-up' is not appropriate."

Where the chief complaint is found: Although some coders were trained to only look for a chief complaint in one particular section of the documentation, that is inaccurate. "The chief complaint may be listed as a separate element of the history, or it may be included in the history of present illness (HPI) -- and that's very important," Weiss said.