Codify
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# Dermatology Coding Alert

## E/M Coding: Implement These 5 Simple Steps to Boost Your E/M Bottom Line

**Heads up: Dig past 'follow-up' for acceptable chief complaint.**

E/M coding might be part of your everyday routine, but that doesn't mean you have to fall into a coding rut. An education expert with Palmetto GBA, a Part B MAC in seven states, offers five simple ways to keep your claims clean and sailing through the reimbursement process.

Step 1: Change the Documentation Wording

Although you might think of "cloned documentation" as only existing when using electronic health records (EHRs), the truth is that even paper records can be considered "cloned," if they are all worded exactly alike. The answer? Help providers remember to document things differently, so they don't look like carbon copies.

"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," says **Carrie Weiss**, senior provider education consultant with Palmetto.

Even if the physician sees seven patients with dermatitis 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.

Step 2: Verify That Provider Signatures Are Legible

Practitioners who are signing documentation by hand should ensure that they include both their first and last names, and that the signature is 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 require a signature log or attestation statement to determine who authored a medical record entry. If a signature is missing from an order for other services, the order will be disregarded as if it didn't exist.

Step 3: Grab the Billing Provider's Signature for Ancillary Services

If ancillary staff members perform a service and write documentation, you may need to have the record signed by the practitioner who is billing for the service. This is state specific, as Medicare does not require the physician to sign incident-to documentation. The medical record only needs to be signed if the state requires the NP, PA, or other practitioner's notes to be counter-signed by the physician.

Step 4: Choose Between 1995 and 1997 Guidelines for a Single 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 warns. "So once you start out using a set of guidelines for an encounter, 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."

Step 5: Avoid 'Follow-Up' as a Catch-All 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 says. "It is typically stated in the patient's own words. An example would be a sore throat, or ear pain. Just stating 'follow-up' is not appropriate."

**Find it:** 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.