Internal Medicine Coding Alert

Standardized Forms Can Facilitate Coding and Increase Billing Efficiency

In the August issue of Internal Coding Alert (Protect Compliance, Educate Physicians, Increase Efficiency, and Detect Lost Revenue: Perform Internal Coding Audits on page 59) we discussed the benefits of performing internal chart audits to detect coding and documentation problems in your practice. According to our sources, a key problem often unearthed in internal medicine groups is poor documentation of evaluation and management (E/M) services, which results in incorrect code assignment.

If this is true in your office, what can you do to remedy the problem? Should you schedule more seminars for the physicians? More education for the coders? These are options, but a practical solution to many documentation problems is to design standardized forms for obtaining patient history and documenting the physical exam that make it easier for coders to understand what service the physician performed. At the same time, these forms can also prompt the internist to remember to document important information. (See insert for reference when making a form specific to your practice.)

I am a firm believer in the use of standardized forms as much as possible, says **Barbara J. Cobuzzi, MBA, CPC,** the president of Cash Flow Solutions Inc., a physician-practice billing company in Lakewood, NJ. I know some physicians do not like to use them. But one of the areas physicians tend to fall short in is their review of systems. And its not that they dont ask all of the questions, but to justify a high level of service you had to have reviewed 10 or more systems. They tend to not completely document this. Instead, they tend to be very problem focused.

Cobuzzi does a lot of education with her physician practices and also helps the groups to develop forms that will facilitate appropriate coding and billing.

Designing a Patient History Form

When I consult for a practice, the first thing I ask to see is a copy of all of their forms, says **Randy Thompson, CPC,** a practice management and coding consultant with Health Care Consultants of America Inc. based in Augusta, GA. Frequently, the practices form for the patient history is incomplete or asks for information in ways that will not aid the physician in establishing a proper medical history.

One example is a form that I filled out in a physicians office, he explains. For the review of symptoms, there was a list of signs and symptoms, and the questions asked, Do you have or have you ever had any of the following? I consider the ROS to be a condition that is currently occurring as opposed to an illness in the past. One of the items ended up reading Have you ever experienced nausea or vomiting?

The form did not differentiate properly between the history of present illness, the review of systems, and the past medical history.

If you have a form that is ineffective, the physicians will not use it. Thompson also noticed that the physician did not refer to the history form the entire length of the visit.

A good patient history form should include separate sections for the HPI, ROS, and PFSH.

The form should have blanks for the patients name, date, and reason for visit. Under the HPI section, the patient should answer questions about the time the problem started, how often the problem occurs, any conditions under which the

problem worsens, and any attempts the patient has made to treat the problem.

The review of systems can indeed be covered by a list of symptoms in the main organ systems and body areas.

You can choose items that reflect the symptoms most commonly seen in your practice or specialty, he says.

Healthcare Consultants of America (HCCA) has several standardized forms on diskette that are available to practices. The practices can download the forms into their office computer and alter them to fit their needs. Healthcare Consultants of American Inc. can be reached at 1054 Claussen Rd., Suite 307, Augusta, Ga. 30907. Phone: 706-738-2078. Fax: 706-738-9839. Or contact HCCA on the World Wide Web at http://www.hccainc.com.

The list of symptoms under the ROS should be bullet style, but in such a way that it requires the patient to respond.

He recommends the overall question Are you having any of the following? be followed by the list of symptoms. Next to each symptom he would place two check boxes, indicating either a Yes or No response.

That way the patient must check something; they cannot leave the question blank, he says.

The past medical, family, and social history would contain history questions pertinent to the specialty, in this case internal medicine.

I would ask for input from the physicians on the questions they would normally ask, Thompson advises.

For internists, the history form may actually take up two pages, advises **Kathryn Cianciolo, MA, RRA, CCS, CCS-P,** chair of the Society for Clinical Coding at the Chicago, IL-based American Health Information Management Association, the representative organization of 38,000 health management professionals.

There are often a lot of things for these physicians to go over, she says. It may take up more than one page. But, you can print information on the front and back of one sheet.

Designing an Examination Form

Thompson and Cianciolo say many practices design several examination forms: one for a general, established-patient exam, and others that can be tailored for specific illnesses or injuries the practice frequently sees.

On the examination form, Thompson recommends that blanks for the patients name and the date be placed at the top. Other space, located on the next line, should prompt the physician to record the date of the history information he reviews prior to examining the patient. There should also be prompts for the physician to indicate any changes in the ROS of PFSH that the patient tells the physician of during the visit, and a place to record the chief complaint and pertinent information. Spaces to record the patients vital signs are also important.

On the general examination forms that he designs, Thompson lists the organ systems and body areas that are pertinent to the particular specialty. For internal medicine, this would be all of the systems.

Under each system/area, he lists what the HCFA and the American Medical Association (AMA) have determined are normal findings for each system.

For example, under the Respiratory heading, there are bullets to indicate:

respiration, non-labored
clear to auscultation bilaterally.

A check in both boxes indicates that these systems were examined and the findings were normal. Many physicians do not remember to document normal findings, only those that are abnormal, he explains.

The list of systems with normal findings is placed along the left edge of a large blank area on the form that can be used to document any abnormal findings.

Other spaces on the form indicate the assessment/diagnosis plan, any lab tests ordered and any tests performed.

I also have a specific blank for the appropriate diagnosis code to accompany the lab test ordered or test performed by the physician, Thompson states. That eliminates many of the denials for medical necessity.

Note: Without the additional information, coders may link the tests with the diagnosis code for the overall visit, which may not be the same as the problem for which the test was ordered. The appropriate code is necessary to justify the medical necessity of the test ordered to Medicare and other third-party payers.

Special Forms for Other Problems

Some groups design special standardized forms that serve as the progress notes for problems that are frequently seen by the group, she says. For example, laceration repairs often have their own form.

In addition to the other information, the form has a space prompting the physician to record the length of the laceration, and the depth. This information is necessary for coders to choose the right level of wound repair code to apply.

Also, some groups use forms with pictures of the various body areas so that the physician can draw on the picture to indicate the position and type of wound and the repair that was performed, she says. That helps because you dont just get the doctor trying to draw his own figure on a piece of paper. That is very hard to read and understand what service the physician provided.

Shadow Physicians Before Designing Form

If forms are new to your practice, you might want to spend a few days following your physicians through each step of an office visit to determine which questions are asked and which prompts to include on the form.

I followed a physician for a day, and after about six or seven established-patient visits, I had about 90 percent of the questions he always asked, Thompson says.

These questions were incorporated into the design of the examination form.

In designing a form for laceration repair or other typical internist visits, coders could ask to shadow the physician on these particular services.

Tip: This can also be helpful when learning to code a new procedure or service.

Benefits of Form Usage

The best forms can replace the physicians progress note and serve as the actual documentation of the medical visit, says Cianciolo.

This saves a lot of time, she says. Some physicians still prefer to dictate their notes and, in this case, the form can at least serve to remind them to dictate a particular piece of information that might be vital. And it can help them organize the information.

Using the forms for documentation of the history and physical exam can save the practice time and money, Thompson agrees.

You save the time spent dictating, the time and money spent having the dictation transcribed, and the time the physician must spend going over the transcription of the tape to ensure that the documentation is correct, Thompson

says.

Thompson adds that, in many internal medicine offices, he has seen the increased efficiency permit the physicians to see an average of one additional patient per day.

And, that can result in more money coming into the practice, he states.