Part B Insider (Multispecialty) Coding Alert

CODING & COMPLIANCE: Don't Turn Your E/M Claims Into Audit Bait

Look for questions that go beyond the patient's 'chief complaint'

When assigning an evaluation & management level to your doctor's visit, don't get hung up on trying to make statements go as far as possible. Rather, you should pay attention to how in-depth the doctor went with questions, say experts.

You can credit the same statement for both the history of present illness (HPI) and the review of systems (ROS) in some cases, officials from the **Centers for Medicare & Medicaid Services** (CMS) and some carriers have said. (See PBI, Vol. 8, No. 9). But that doesn't mean you can stretch one statement to bump up a visit where the doctor only focused on the presenting problem.

Reality check: In situations where the potential for HPI/ROS -double dipping- comes into play, -a reality check should help a coder make the correct decision,- says Todd Thomas, president of **Thomas & Associates** in Oklahoma City, OK. Ask yourself: Did the doctor look beyond the presenting problem for more information about what was going on with the patient?

For a problem-focused history, the physician only needs to obtain one to three elements of HPI information, Thomas notes. No ROS information or past social or family history (SPFH) is necessary. But for an expanded problem-focused history, the doctor would ask about other, possibly related symptoms or problems.

Example: When Bellevue, WA physician **Mason Smith** wrote to then-CMS official **Barton McCann** to ask if it was okay to use the same statement in both HPI and ROS, Smith used the example of a patient presenting with abdominal pain. The doctor asks whether the patient has nausea. This question showed that the doctor looked past the presenting problem, says Thomas.

If the chart only documented a presenting problem of abdominal pain without any additional information, an -aggressive-coder could try to use that one statement as a chief complaint, location in the HPI and gastro-intestinal information in the ROS. That might technically qualify as an expanded problem-focused history, but it would be -a problem in an audit situation,- says Thomas. The doctor has only identified the presenting problem.

Bottom line: -It would not be appropriate to document the same information twice just to meet documentation requirements,- says **Larry Levine**, a coding and compliance expert in Washington, DC. -If the duplicate information is not medically necessary, the duplicate information will not withstand the scrutiny of a payer audit.-