Part B Insider (Multispecialty) Coding Alert

E/M Coding: Boost Your Practice's E/M Levels With One Tiny Scribble

Warning: SOAP notes won't hold water

Your doctor doesn't have to be a poet to generate winning evaluation and management documentation.

But if your doctor is neglecting to put down notes that indicate she reviewed a patient's systems in full when taking her history, then you could be composing a lament for your lost reimbursement. One simple note - "all other systems negative" - can help boost your E/M levels, say coding experts.

Physicians often leave out the review of systems piece of medical documentation altogether, says consultant **Cindy Parman** with **Coding Strategies** in Atlanta. Doctors may do a great job with history of present illness, physical exam and medical decision-making, but "that little [review of systems (ROS)] piece is the one that doesn't get in there," Parman reports.

Parman cites one doctor who was billing all new patients as level three visits. "If he had just put, 'All other systems reviewed and negative,' he would have had all fours and fives," she notes.

All the doctor has to do is "comment on anything pertinent" in the ROS and then mention that everything else is negative, Parman adds. It also helps to cross-reference the record by saying, "for additional documentation see complete ROS as documented in this chart May 1, 2002."

"I can give you some really funny examples" of physician mistakes in this area, says consultant **Georgeann Edford** with **Coding Compliance Solutions** in Birmingham, MI. Sometimes, a physician will write the history of the present illness, including how long the patient has had the complaint and what the patient has tried, and then under that scribble, "ROS: all others negative." But because the physician hasn't mentioned any positive ROS findings, this note is worthless, says Edford.

The patient's documentation must have information about the systems the physician reviewed which yielded some information, such as night sweats or vomiting, before the physician can write "all others negative," Edford explains.

Once the physician has noted all other pertinent facts, though, he/she can spruce up the documentation to note, "all others negative," says **Dalrona Harrison** with **Preferred Health Systems** in Wichita, KS.

The worst documentation comes from physicians who have learned to take SOAP (Subjective Objective Assessment and Plan) notes in medical school, Edford adds. These notes include subjective information, which often turns into the history of present illness (HPI), and objective info, which becomes the physical exam. But physicians using the SOAP note rarely include a comprehensive ROS in their documentation, says Edford.

However, as long as the physician reviews the pertinent systems, no other details are necessary, says **Tina Landskroener** an independent coding consultant in Las Vegas, NV. If a patient comes in with chest pain, "I want to know that you reviewed all the chest and other organs, but I don't care if the big toe hurts."

Also, if a patient comes in with a bug bite, reviewing every single system in detail isn't going to add up to a high-level E/M visit, Landskroener cautions. But when in doubt, if the physician really has reviewed all the systems, it's good to note that fact. "If you don't mark it, it won't count for you," she concludes.

"Providers are getting a little bit better" at E/M documentation, says Harrison. "It's been drilled so much into their heads,"

and the tenth anniversary of the 1995 guidelines is coming up. "People are finally saying maybe these aren't going away," and also making the move from checking off boxes to creating documentation that reflects the work they're doing, Harrison says.