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Part B Insider (Multispecialty) Coding Alert

EMR Issues: See How An EMR Upcoded This Visit by Two Levels

Review this documentation and determine how you'd code it before you read the solution.

When you review a particularly thorough E/M note, your first instinct may be to agree with an EMR's selection of a high-level code for the physician's extensive work. But if just one element of a particular code isn't met, you won't be able to report it even if the rest of the documentation is pristine. This is true even if an EMR selects a high level for you.

Check out the following note that a family practice physician documented and determine where the EMR may have bumped up his service level.

Code reported: 99214

Chief complaint: Follow-up for left shoulder pain following completed therapy. She says she is much better due to therapy combined with the medicine.

HPI: This is a 66-year-old, right-hand dominant female who presents for a follow-up for her left shoulder pain. We last saw the patient 56 days ago. She was diagnosed with left shoulder impingement syndrome and was started on anti-inflammatory and icing regimen, and was referred for formal PT. She has been going to therapy for the past 5 weeks and has completed the regimen. States that she did very well with the therapy and was happy with the outcome. Her pain is markedly decreased and she has a full range of motion with improved strength. She denies any new complaints today.

PMFSH: She currently has no other conditions and has never had any surgeries. She does not drink and has never smoked. Her mother had diabetes and hypertension. She lives alone in her home with no pets, and is retired from her job as a school counselor. She plays tennis and walks for exercise. She has never been married and has no children.

ROS: Patient reports no fever, no night sweats, no weight gain or loss, and no exercise intolerance. She reports no dry eyes, no irritation, and no vision change. She reports no difficulty hearing and no ear pain. She has never had a nosebleed and has no nose or sinus problems. She reports no sore throat, no bleeding gums, no snoring, and no dry mouth. She reports no chest pain, no arm pain on exertion, no shortness of breath when walking, and no shortness of breath when resting or lying down. She has no cough, no wheezing, no shortness of breath, and no coughing up blood. She reports no abdominal pain, no vomiting, normal appetite, no diarrhea, and not vomiting blood. She reports no incontinence, no difficulty urinating, no hematuria, and no increased frequency. She reports no muscle aches, no muscle weakness, no arthralgias/joint pain, no back pain, and no swelling in the extremities. She has no abnormal moles, no jaundice, and no rashes. She reports no loss of consciousness, no weakness, no numbness, no seizures, no dizziness, and no headaches. She reports no depression, no sleep disturbances, and no alcohol abuse. She reports no fatigue. She denies swollen glands or bruising. She reports no runny nose, no sinus pressure, no itching, no hives, and no frequent sneezing.

Physical Exam:

General: Patient is a 66 year-old very pleasant female.

Constitutional: General appearance: Healthy appearing, NAD, and normal body habitus.

Psychiatric: Oriented to time, place, and person. Normal mood and affect, and active and alert.

Cardiovascular: Arterial pulses right: subclavian normal and compression test negative and carotid normal, radial normal, brachial normal, and halstead maneuver negative. Arterial pulses left: carotid normal, radial normal, brachial normal, subclavian normal, and halstead maneuver negative. Edema right: none. Edema left: none. Varicosities right: no

varicosities and capillary refill test normal. Varicosities left: no varicosities and capillary refill test normal.

Lymph nodes: Inspection/palpation right: no cervical LAD, supraclavicular LAD, or axillary LAD. Inspection/palpation left: no cervical LAD, supraclavicular LAD, or axillary LAD.

C-spine/neck: Active range of motion: no crepitus or pain elicited on motion and flexion normal, extension normal, rotation normal, and lateral flexion normal. Passive range of motion: flexion normal, extension normal, rotation normal, and lateral flexion normal.

Shoulders: Inspection of both shoulders showed: No misalignment, atrophy, erythema, induration, swelling, warmth, or scapular winging and AC prominence normal. Inspection left: Bony palpation of both shoulders showed no tenderness of the suprasternal notch, the sternoclavicular joint, the clavicle, the coracoid process, the acromioclavicular joint, the acromial, the greater tuberosity, the bicipital groove, or the scapula. Soft tissue palpation right: no tenderness of the region, the pectoralis major insertion, the sternocleidomastoid, the costochondral junction, the trapezius, the rhomboid, the lattisimus dorsi, the serratus, the deltoid, the levator scapulae, or the lateral cuff insertion. Soft tissue palpation left: No tenderness of the suprasinatus, the infraspinatus, the teres minor, the subacromial bursa, the subdeltoid bursa, the axilla, the glenohumeral joint region, the pectoralis major insertion, the sternocleidomastoid, the costochondral junction, the trapezius, the rhomboid, the lattissmus dorsi, the serratus, the deltoid, the levator scapulae, or the lateral cuff insertion. Active range of motion in both shoulders was normal, with external rotation at 0 degrees of abduction normal. Special tests left: Hawkin's test negative, Neer's test negative, O'Brien's test negative, Speed's test negative, empty can sign negative, subscauplaris strength tests normal, and Yergason's test negative. Strength right: abduction 5/5, adduction 5/5, flexion 5/5, extension 5/5, external rotation at 0 degrees of abduction 5/5, and internal rotation 5/5. Strength in left shoulder is about 5 to 10 percent less than right.

Skin: Normal on both left and right upper extremities.

Assessment/Plan: Rotator cuff syndrome of shoulder and allied disorders (726.19). We are very happy with the way the patient has progressed with therapy. She has been advised to continue her home exercise program to keep working on the strength of the rotator cuff. We will see her again on an as-need basis.

Find Out Where This Physician Went Awry

Did you spot the problems with this chart? Based on the chart alone, the EMR coded it with 99214 due to the detailed history and comprehensive exam. However, the medical decision-making for this follow-up patient is of low complexity, which only qualifies it for 99212.

Here's why: According to CMS, medical necessity should always be the overarching factor that your doctors use to select the E/M service level. Just because a physician completes a higher level history and examination doesn't mean he always should report a higher level code. Medical necessity should drive the components that he performs. Comorbidities, the need for diagnostic testing, the plan of care, and so on, may complicate the encounter and increase medical decision-making, and warrant additional history and exam as well. However, in this case, the medical decision-making was not complicated for this otherwise healthy patient.

"CMS has provided strong directives that each note (no matter how it is created) should be specific to the patient, the encounter, and the problem," advises **Suzan Hauptman, MPM, CPC, CEMC, CEDC,** manager of physician compliance auditing with West Penn Allegheny Health System. "The note in the example above is not necessarily specific to the encounter, as much of the patient's problem was resolved," she adds.

What to look for: In this case, in which the physician was examining a mostly resolved shoulder issue, your suspicion that he may have overdocumented the history would be piqued when you saw that the doctor reported on whether the patient had conditions such as jaundice, seizures, or vomiting blood. If she had other issues that may have caused these problems, then these would be relevant to the shoulder exam, but in this case, the medical necessity to recheck a shoulder problem would not typically drive the physician to check these issues.

Bottom line: If your EMR prompts you to record all areas of history and exam□or worse yet, doesn't let you exit a record

until you've covered all of the areas—then it's time to tweak your system. Turn to our article, "Work With EMR Vendor on Templates" on page 194 for tips on how to ensure that your EMR works well for your practice.