Part B Insider (Multispecialty) Coding Alert

EVALUATION & MANAGEMENT: How To Improve MDM Documentation

Boost your E/M levels by fixing your decision-making

Is medical decision-making the reason for your woes? Some experts say "Yes."

The Medicare Carriers Manual, section 15501(a), states that "medical necessity of a service is the overarching criterion for payment," notes consultant **Georgeann Edford** with **Coding Compliance Solutions** in Birmingham, MI. Thus, if the patient didn't need that much medical decision making, then the need for the services was automatically less than the history and physical might indicate.

Sometimes a patient may simply need a lot of exam and history but less MDM, notes **Joan Gilhooly** with **Medical Business Resources** in Chicago. For example, if a patient comes in complaining of abdominal pain and the "differential diagnosis is a mile wide," the physician must consider a lot of things. In the end, the patient may turn out to have a simple problem, but the physician eliminates a lot of diagnoses along the way.

But sometimes the physician actually makes some crucial decisions and then doesn't document them properly, and that can pull down the E/M code levels .

Edford says she often goes back through a physician's notes during litigation, and especially for regular patients, "some of these notes are so scanty." The physicians know the patients, so they don't bother to write anything down, she says. "Do they expect the coder to have ESP?"

Often, physicians won't state whether a disease has progressed as expected, notes Gilhooly. So the coder will assume that's the case, even though that's a level of clinical judge-ment a coder shouldn't be making. She encourages physicians to use one of two phrases, as applicable: "Patient not improving as hoped," or "Failing to respond as expected." That lets the coder know that "there's something wrong here that you're going to have to pursue." That way, the coder can give the physician more credit for MDM.

If the physician had to look back at old records, it's really important to mention that fact, says Gilhooly. Ideally, the physician should say more than just, "reviewed old records," but should explain what he/she found in the old records. Also, sometimes the physician will have to take a history from someone other than the patient, such as a family member, caregiver or spouse. Maybe the patient is demented or confused, or not able to talk. "As coders we can't assume the info came from someone else," but mentioning that fact briefly will allow the coder to give more credit.

If the patient has a few possible diagnoses, it's important for the physician to list them, notes Gilhooly, "especially if there's going to be tests ordered." The physician should write something like, "ordering CT to rule out tumor," or explain that the patient needs a CT to distinguish between a tension headache and a migraine. "Give us a hint on the nature of the presenting problem or the table of risk," urges Gilhooly.

Sometimes physicians just list the tests they're ordering in the encounter ticket or superbill instead of in other documentation. And then the practice may throw away the encounter ticket after a few months, destroying that information, Gilhooly complains. Practices should hold onto encounter tickets for at least seven years, but physicians should also note which tests they ordered in the progress notes.

And finally, physicians sometimes fail to note the difference between over-the-counter and prescription medications. Some drugs are available in prescription strength as well as nonprescription, notes Gilhooly, including ibuprofen. If the doctor doesn't specify a prescription med, the coder may assume otherwise and drop the level of risk involved.

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