Part B Insider (Multispecialty) Coding Alert

Part B Revenue Booster: Boost Your Bottom Line With These 3 E/M Documentation Steps

Tip: Don't miss the endocrine system when you're tallying ROS

One missed documentation element could mean the difference between reporting 99212 and 99213. Our experts weigh in on how to code E/M office visits correctly and increase your bottom line.

Often, physicians are stingy on documentation in key areas. They ask the appropriate questions and perform the service, but may not document the question-and-answer portion very well. For instance, one coder reveals that she has one physician on staff "who rarely documents past, family or social history, another who documents past medical only, and another physician who documents only past and social." Read on and we'll show you how to escape these problems.

Step 1: Create a Form

One way to ease your documentation challenges is to create a form that targets the four types of history. Such forms usually feature blanks and check blocks to allow the physician an easy way to document pertinent details of the visit. The forms should include blanks for completion, check blocks when applicable (negative system issues, normal exam findings, etc.), and areas for additional information. Included would also be instruction as to who can document where, proper signatures with dates and sometimes time, and areas to explain unusual circumstances (patient co-morbidities, records requests, personal viewings of films, etc.)

Step 2: Don't Overlook Systems

Another common problem is when coders select a code without looking at all of the potential systems that the physician reviewed. One commonly overlooked area is the endocrine system. If the physician notes that the patient has experienced weight gain and lethargy, and requests tests to rule out a thyroid condition, you can count that toward the endocrine system.

You should also look at whether the physician reviewed the psychiatric system. For instance, if the patient says, "I've had this back pain for three months, and it is starting to make me depressed," you may count the depression toward the psychiatric system in the review of systems.

Keep in mind: The physician might elaborate the frustration level of the patient as opposed to an actual "depressed" state regarding the pain. It could also go to severity or timing in the history of present illness (HPI), depending on how it is further illustrated. For example, "The pain is so bad that it makes me depressed," or "I am depressed at how long this pain has been affecting me."

Step 3: Don't Neglect PFSH

Past history refers to the patient's own medical history, including current medications and allergies. Family history includes medical events in the patient's family line, such as familial rheumatoid arthritis or diabetes. Social history, alternatively, reviews the individual's past and current activities (for example, occupational history or use of drugs).

Keep in mind: Your physician will likely ask established patients about their current medications (past history) and social history (are you working, how are you functioning, what are you able to do, and so on). Questions regarding family history may not be appropriate, particularly if your physician already addressed this at the initial patient visit.