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E/M from a Physician's Perspective – clairvoyance into the physician mind

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Goals

- Insight into the physician view of the coding process;
- Review the physician / coder interactions;
- Discuss potential solutions to overcoming barriers in physician coding comprehension.

Overview

- Traditional Teaching
  - Chart
  - Procedures
  - Diagnoses
- System of Work
- Cloning
- ICD-10
- Remediation

RBRVS

- No longer get paid for what you do
- You get paid for what you document

  - Very complex system for revenue generation
  - Down-coding due to poor documentation
  - Loss of legitimate revenue

HPI

HPI – standard teaching

- "You need to include at least 1 in 4 of the 8 categories to bill a level 5…."

Location	Timing
Severity	Context
Quality	Modifying Factors
Duration	Associated Symptoms

HPI – the Clairvoyant Coder

Document your usual history…"

PLUS

- What makes the condition better - or worse
- Treatment before arrival
- Pain scale

"*If the history is not obtainable say so AND WHY…*"

- Pt condition
- Acuity
- Language
- Age
- No Family / Records

"…but *still document what you can …*"

- Other sources
- Records, family, rescue, nursing notes etc

PM/F/S

PM/F/S – standard teaching

PM/F/S– the Clairvoyant Coder

"*Document the medical & surgical history important for the patient …*"

- Do they smoke – YES or NO
- Who do they live with?
- If the pts has no history you MUST documents no PMHX

ROS
ROS – standard teaching

ROS – the Clairvoyant Coder
"*Do the pertinent positives & negatives…*"

- Review the major organ systems
- **All systems reviewed and otherwise negative**

"*If HPI is unobtainable then ROS is unobtainable…*"

- Charting must be set up to support this -

PE
PE – standard teaching

PE – the Clairvoyant Coder
"*Document your usual exam…*"

- Vital signs
- Constitutional / General Appearance
- Never document something that was NOT done…

MDM
MDM – standard teaching

MDM- the Clairvoyant Coder

- Document all labs, x-rays & tests
- Document your interpretations
- Document speaking with consultants
- Perform and document re-evaluations
  - Especially after interventions

Critical Care Time

- Failure to correctly document critical care time is one of the largest areas of revenue loss for many groups
- **Most physicians underestimate their critical care work**

Preventing Revenue Loss
Things are not intuitively obvious to physicians

Procedures

- Every procedure performed by the physician (including failed procedures) should have a procedure note documented in the patient chart

- Docs think about this in medico-legal terms
  - You think about it in terms of BILLING

Procedures – the Clairvoyant Coder

"Document the procedure the same way – every time – succeed or fail"

- What
- Why
- How
- Who

- Time out
- EBL

YES
IV starts EJs Foleys NGs

Every procedure needs a supporting diagnosis

- Central line – *hypotension, shock, dehydration*
- Intubation - *respiratory or airway compromise*
- LP – *HA, meningitis, fever*
- Orthopedic reduction – *dislocation of "ABC"*
- I & D – *"3cm right forearm abscess"*

Specify the location & size for EACH

Equipment replacement must have the reason patient requires the device:

- G-tube - *CVA, malnutrition, FTT*
- Foley – *Urinary Retention*
- IV – *Dehydration, infection*
- Trach – *Tracheal stenosis*

Diagnoses – the Clairvoyant Coder

Document all diagnoses

- Use the chief complaint
- Include abnormal vital signs
- Hypoxia, tachycardia, hypertension
- Include abnormal labs

Document physical findings

- Dehydration
- Jaundice
- Dizziness
- Weakness
- Fever

Add the chronic medical conditions

- HTN CRF EtOH Abuse
- DM CAD

Diagnoses - psychiatric

- Include all DSM dxs & medical dxs
- MDE, Suicidal Risk, EtOH ingestion
- Acute psychosis, SI, schizophrenia
- SPECIFIC drug ingestion / over dose
- Chronic medical complaints

Acute abdominal pain is NOT a diagnosis - Must have a location

- RUQ
- Epigastric
- Lower
- Diffuse
- NOS

Strain must have an overuse syndrome documented in the chart

UTI & Sepsis – not urosepsis - is a better diagnosis

Diagnosis - gold stars

- Acute
- Sudden onset
- Severe

Intractable
Exacerbation
Acute febrile illness

Diagnosis NO NOs

- Normal / Mild — Resolved
- Medical screening* — Medical clearance
- Med refill — Well baby*
- Parental anxiety — Multiple contusions
- Possible / Rule out — Suspected
- MVA or MVC — SI

Systems

Does the charting system support the physician work?

- Is it easy to use?
- Does it have prompts?
- Is it logically formatted?

- Does it accomplish what it should?
  - Patient care
  - Communication
  - Billing / Coding
  - Medical - legal

EMR

You can tell "who" created the EMR
Many EMRs handle linear patient encounters well
Most EMRs do NOT handle non-linear patient encounters well

All EMRs increase the provider work

- Time
- Actual work (CPOE)
- Multiple screens

All EMRs have positives

- Legibility
- Data exchange / flow
- No more Easter egg hunts

and Negatives……

Legibility
Data exchange / flow
No more Easter egg hunts

EMR – the Clairvoyant Coder

- Customization
- Communication
- Persistence
- Flexibility

Cloning – the Clairvoyant Coder

ICD-10 – the Clairvoyant Coder

- It is all about physician education

Remediation – the clairvoyant coder

No Outcome = No Income