Compliant Documentation in the EHR

Lynn Myers MD, CPC, CHC

Introduction

• The perspective of a physician and a coder
• Going over to ‘the dark side’ of medicine
• Death by a thousand cuts?
• Why it helps coders to know the basics of EHR systems when working with providers.
Learning Objectives

• Documenting the Key Components of an Office Visit
  – 1997 Guidelines
• How does the E&M Calculator work?
• What is Compliant Documentation?
  – Scribes
  – Transcription
  – Closing encounters

Key Components of an Office Visit

Key Components are:

◦ History $HPI + ROS + PFSH$
◦ PE
◦ Medical Decision Making $Problems + Data + Risk$

Common Errors

◦ Diagnoses listed in Assessment and Plan that are not addressed elsewhere
◦ No indication that diagnoses or problems led to physician work
◦ No key component info to support plans or conclusions
◦ “Follow up”
◦ Providers using dictation tend to mix elements
The HPI (Reason for Visit)

- History - composed of HPI, ROS & PFSH
- Types of History
  - Brief - meaning at least one element
  - Extended - more than four elements
- Chief complaint must be identifiable (unless Preventive Visit)
- Must be documented by the provider!

### History Elements

<table>
<thead>
<tr>
<th>Descriptor</th>
<th>Definition</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location</td>
<td>Where is it</td>
<td>Abdomen, Right Lower Quadrant</td>
</tr>
<tr>
<td>Duration</td>
<td>How long have you had it or how long does it last</td>
<td>2 weeks, injury date 12/01/05</td>
</tr>
<tr>
<td>Quality</td>
<td>Descriptor of the lesion/problem or symptom</td>
<td>Sharp, Scaly, Red, Achy, Generalized</td>
</tr>
<tr>
<td>Severity</td>
<td>Intensity of the problem</td>
<td>2 out of 10, moderate, worst it has been</td>
</tr>
<tr>
<td>Timing</td>
<td>When does it occur</td>
<td>nocturnal, worse in the morning, intermittent, constant, every 2 hours</td>
</tr>
<tr>
<td>Context</td>
<td>What happens or happened to cause the symptoms?</td>
<td>twisting injury in sports, happens after eating spicy foods</td>
</tr>
<tr>
<td>Modifying factors</td>
<td>Something that makes it better or worse</td>
<td>Advil makes it better, pain increases with standing all day</td>
</tr>
<tr>
<td>Associated Signs and Symptoms</td>
<td>Other symptoms noted by the patient that may or may not be related to the primary complaint</td>
<td>Complaint - Neck pain / Pt reports numbness Complaint - Head injury / Patient reports nausea</td>
</tr>
<tr>
<td>Status of 3 Chronic Problems</td>
<td>Chronic conditions and a brief statement of how the patient is doing</td>
<td>Diabetes, doing well on insulin B9 HTN, not exercising, on meds Asthma, using inhaler q 3 hrs</td>
</tr>
</tbody>
</table>
## History Types

<table>
<thead>
<tr>
<th>Type of History</th>
<th>CC</th>
<th>HPI</th>
<th>ROS</th>
<th>PFSH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem Focused</td>
<td>Required</td>
<td>Brief (1-3) / 99212-3 / 99202</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Expanded Problem Focused</td>
<td>Required</td>
<td>Brief (1-3) / 99212-3 / 99202</td>
<td>Problem Pertinent (1) / 99212-3 / 99202</td>
<td>N/A</td>
</tr>
<tr>
<td>Detailed</td>
<td>Required</td>
<td>Extended (4+) / 99214-5 / 99203-5</td>
<td>Extended (2-9) / 99214/99203</td>
<td>Pertinent</td>
</tr>
<tr>
<td>Comprehensive</td>
<td>Required</td>
<td>Extended (4+) / 99214-5 / 99203-5</td>
<td>Complete (10+) / 99214/99203</td>
<td>Complete / 99215 / 99214-5 for established / 3 for new patients</td>
</tr>
</tbody>
</table>

### HPI Calculation

- **Brief HPI** = 1 to 3 elements (99212-3/99202)
- **Extended HPI** = 4 + elements or status of 3 chronic conditions (99214-5 / 99203-5)
The ROS

ROS
- Problem Focused – One system
- Extended Problem Focused – one to two systems
- Detailed two to nine systems
- Comprehensive – greater than ten systems

- More easily counted if separate from HPI
- Reflect problem-pertinent
- Must state the positives
- Validate, if data entered by staff

Systems
- Constitutional
- Eyes
- ENMT
- CV
- Resp
- GI
- GU
- MS
- Integumentary
- Neurological
- Psych
- Endocrine
- Hem/Lymph
- Allergic/Imm

ROS in EMR & Guidelines

<table>
<thead>
<tr>
<th>EMR</th>
<th>GUIDELINES</th>
</tr>
</thead>
<tbody>
<tr>
<td>General</td>
<td>Constitutional</td>
</tr>
<tr>
<td>Skin</td>
<td>Integumentary (skin and/or breast)</td>
</tr>
<tr>
<td>HEENT</td>
<td>Eyes</td>
</tr>
<tr>
<td></td>
<td>Ears, Nose, Mouth &amp; Throat</td>
</tr>
<tr>
<td>Neck</td>
<td>Respiratory</td>
</tr>
<tr>
<td>Respiratory</td>
<td>Respiratory</td>
</tr>
<tr>
<td>Breast</td>
<td>Cardiovascular</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>Cardiovascular</td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>Gastrointestinal</td>
</tr>
<tr>
<td>Genitourinary</td>
<td></td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td>Musculoskeletal</td>
</tr>
<tr>
<td>Neurological</td>
<td>Neurological</td>
</tr>
<tr>
<td>Psychiatric</td>
<td>Psychiatric</td>
</tr>
<tr>
<td>Endocrine</td>
<td>Endocrine</td>
</tr>
<tr>
<td>Hematology</td>
<td>Hematologic/Lymphatic</td>
</tr>
<tr>
<td>Allergic/Immuno</td>
<td>Allergic/Immunologic</td>
</tr>
</tbody>
</table>
**ROS Calculation**

1 System = Problem Pertinent

2-9 Systems = Extended (99214/99203)

10 + Systems = Complete (99215/99204-5)

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**The PFSH**

‘Include Active’, links to PFSH in templates, or pulling forward the historical data is not always the best option, especially for lower levels of service where this category is not required. Even though staff may enter this data, in order to count toward a level of service, it must be acknowledged by the provider. Suggest using a ‘dot-phrase’ or auto-replace text to insert a statement.

PFSH-Past, Family & Social History

- Problem Focused – No categories required
- Extended Problem Focused – No categories required
- Detailed – One category
- Comprehensive – All three categories

Categories

- Past History
- Family History
- Social History
PFSH Calculation

1 History Area = Pertinent

2/3 History Areas = (99215/99204-5)

Established Patient (2) is complete
New Patient (3) is Complete

Adding It Up

<table>
<thead>
<tr>
<th>Overall History Level</th>
<th>HPI</th>
<th>ROS</th>
<th>PFSH</th>
<th>E&amp;M Equivalent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem Focused</td>
<td>Brief (1-3)</td>
<td>None</td>
<td>None</td>
<td>99212/99201</td>
</tr>
<tr>
<td>Expanded Problem Focused</td>
<td>Brief (1-3)</td>
<td>Pertinent (1)</td>
<td>None</td>
<td>99213/99202</td>
</tr>
<tr>
<td>Detailed</td>
<td>Extended (4+)</td>
<td>Extended (2-9)</td>
<td>Pertinent (1)</td>
<td>99214/99203</td>
</tr>
<tr>
<td>Comprehensive</td>
<td>Extended (4+)</td>
<td>Complete (10+)</td>
<td>Complete 2 for est. 3 for new</td>
<td>99215/99204-5</td>
</tr>
</tbody>
</table>
Adding It Up

<table>
<thead>
<tr>
<th>Overall History Level</th>
<th>HPI</th>
<th>ROS</th>
<th>PFSH</th>
<th>E&amp;M Equivalent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem Focused</td>
<td>Brief (1-3)</td>
<td>None</td>
<td>None</td>
<td>99212/99201</td>
</tr>
<tr>
<td>Expanded Problem Focused</td>
<td>Brief (1-3)</td>
<td>Pertinent (1)</td>
<td>None</td>
<td>99213/99202</td>
</tr>
<tr>
<td>Detailed</td>
<td>Extended (4+)</td>
<td>Extended (2-9)</td>
<td>Pertinent (1)</td>
<td>99214/99203</td>
</tr>
<tr>
<td>Comprehensive</td>
<td>Extended (4+)</td>
<td>Complete (10+)</td>
<td>Complete 2 for est. 3 for new</td>
<td>99215/99204-5</td>
</tr>
</tbody>
</table>

The Physical Examination

- Problem Focused – 1-5 bullets
- Expanded Problem Focused – 6-11 bullets
- Detailed – 12+ bullets
- Comprehensive – at least 2 bullets in 9 areas

Be sure to enter details on the problem pertinent elements
## Physical Exam

### Constitutional
- Measurement of any three of the following seven vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (may be measured and recorded by ancillary staff)
- General appearance of patient (eg. Development, nutrition, body habitus, deformities, attention to grooming)

### Neck
- Examination of neck (eg., masses, overall appearance, symmetry, tracheal position, crepitus)
- Examination of thyroid (eg. Enlargement, tenderness, mass)

### Respiratory
- Assessment of respiratory effort (eg., intercostal retractions, use of accessory muscles, diaphragmatic movement)
- Percussion of chest (eg. dullness, flatness, hyperresonance)
- Palpation of chest (eg. tactile fremitus)
- Auscultation of lungs (eg., breath sounds, adventitious sounds, rubs)

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## Exam Calculation

<table>
<thead>
<tr>
<th>Overall Exam Level</th>
<th>General Multi-System</th>
<th>Specialty</th>
<th>E&amp;M Equivalent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem Focused</td>
<td>1-5 bullets</td>
<td>1-5 bullets</td>
<td>99212 / 99201</td>
</tr>
<tr>
<td>Expanded Problem-Focused</td>
<td>6-11 bullets</td>
<td>6-11 bullets</td>
<td>99213 / 99202</td>
</tr>
<tr>
<td>Detailed</td>
<td>12+ bullets</td>
<td>12+ bullets</td>
<td>99214 / 99203</td>
</tr>
<tr>
<td>Comprehensive</td>
<td>at least 2 bullets in each of 9 areas</td>
<td>All bullets in shaded area and at least 1 bullet in each un-shaded area</td>
<td>99215 / 99204-5</td>
</tr>
</tbody>
</table>

Medical Decision Making

Most EMR calculators cannot identify data within free text or dictation to count toward key components. Providers need to understand this, and that the calculator can be manipulated to suggest a higher level of service than is warranted. The calculator may also suggest lower levels of service due to lack of structured data elements.

MDM = Problem Points + Data Points + Risk, combining all three to ensure that your labor and medical necessity are consistent.
- Only 2 of the 3 elements are required to qualify for any level of complexity.

MDM characterized as either:
- Straight forward
- Low complexity
- Moderate complexity
- High complexity

Medical Decision Making

1. Number of Diagnosis and Management Options – based on documentation of diagnoses in A&P and making a qualifying statement (e.g. minor, established stable, established worsening, new)

2. Amount and Complexity of Data to be Reviewed – based on orders such as lab and other testing

3. Risk of Morbidity or Mortality – based on the table of risk. The level of risk is the highest level that fits any one of the three columns.

The final MDM level is based on the highest two of these three.
### Problem Points OR Management Options

<table>
<thead>
<tr>
<th># of Diagnoses</th>
<th>Management Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 pt  Each problem with a treatment plan</td>
<td>0 pts  Continue same or no change</td>
</tr>
<tr>
<td>2 pts  2 plausible DDX, co-morbidities or complications</td>
<td>Drug mgmt, per problem:</td>
</tr>
<tr>
<td>3 pts  3 plausible DDX, co-morbidities or complications</td>
<td>1 pt  3 or less meds/problem</td>
</tr>
<tr>
<td>4 pts  4 or more plausible DDX, co-morbidities or complications</td>
<td>2 pts  4 or more meds/problem</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Management Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 pt  PT, OT or SLT</td>
</tr>
<tr>
<td>1 pt  IVF replacement</td>
</tr>
<tr>
<td>2 pts  Complex insulin Rx or other admix Rx</td>
</tr>
<tr>
<td>1 pt  Rest, heat, ice, specific diet</td>
</tr>
<tr>
<td>1 pt  Joint or soft tissue injection or aspiration</td>
</tr>
<tr>
<td>1 pt  Patient education</td>
</tr>
<tr>
<td>1 pt  Decision to admit</td>
</tr>
<tr>
<td>1 pt  Discuss case with other physician</td>
</tr>
</tbody>
</table>

### Data Points

<table>
<thead>
<tr>
<th>Data Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review/order labs 1-3 procedures…………………………………… 1 pt</td>
</tr>
<tr>
<td>4 or more …………………………………… 2 pts</td>
</tr>
<tr>
<td>Review/order Xrays 1-3 procedures…………………………………… 1 pt</td>
</tr>
<tr>
<td>4 or more …………………………………… 2 pts</td>
</tr>
<tr>
<td>Review Non-radiol reports (echo, PFT, ECG)……….. 1 pt</td>
</tr>
<tr>
<td>Discuss Tests with Performing MD…………………. 1 pt</td>
</tr>
<tr>
<td>Order old records ………………………………………………………… 1 pt</td>
</tr>
<tr>
<td>Personally view/record result of tracing or X-ray…… 2 pts</td>
</tr>
<tr>
<td>Review/document a summary of old records……… 2 pts</td>
</tr>
</tbody>
</table>
### Table of Risk

<table>
<thead>
<tr>
<th>Level of Risk</th>
<th>Presenting Problem</th>
<th>Diagnostic Procedure(s) Ordered</th>
<th>Management Options Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>One minor or self limited problem</td>
<td>Laboratory tests, CXr, EKG, EEG</td>
<td>Supportive recommendations</td>
</tr>
<tr>
<td>Low</td>
<td>Two or more minor problems 1 stable chronic problem Acute uncomplicated illness/injury</td>
<td>Physiologic non-stress tests Non CV imaging with contrast Superficial needle biopsies</td>
<td>OTC Meds, PT, OT IVF without additives Minor surg-no risk</td>
</tr>
<tr>
<td>Mod</td>
<td>Mild exac 1 or more chronic 2 or more chronic stable problems Acute illness + symptom Acute complicated injury</td>
<td>Diagnostic endoscopies Stress tests, endoscopies CV imaging with contrast Obtain fluid from body cavity</td>
<td>Prescription drug management Minor surgery + risk factors Elective major surgery IVF + additives</td>
</tr>
<tr>
<td>High</td>
<td>Severe exacerbation of 1 chronic problem Acute or chronic illness posing threat to life/limb Abrupt change neuro status</td>
<td>CV Imaging with contrast + risks Discography, Cardiac electrophysiologic studies, Endoscopies + risk factors</td>
<td>Major surgery + risk factors Parenteral controlled subst Rx requiring intense monitoring DNR or de-escalation of care</td>
</tr>
</tbody>
</table>

### Calculating MDM

<table>
<thead>
<tr>
<th>Complexity</th>
<th>Problem Pts</th>
<th>Data Pts</th>
<th>Risk</th>
<th>E&amp;M Equivalent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Straight Forward</td>
<td>1</td>
<td>1</td>
<td>Minimal</td>
<td>99212 / 99201-2</td>
</tr>
<tr>
<td>Low</td>
<td>2</td>
<td>2</td>
<td>Low</td>
<td>99213 / 99202</td>
</tr>
<tr>
<td>Moderate</td>
<td>3</td>
<td>3</td>
<td>Moderate</td>
<td>99214 / 99204</td>
</tr>
<tr>
<td>High</td>
<td>4</td>
<td>4</td>
<td>High</td>
<td>99215 / 99205</td>
</tr>
</tbody>
</table>
“It cannot be stressed enough that the volume of documentation is not the sole indication of the level of service. Documentation that is aimed to meet the guidelines for payment but is excessive for the treatment of the patient on the visit in question will not increase the level assigned to that visit.”

NHIC Corp., Provider Education – Medicare Part B 2/28/08

The E&M Calculator

• Tabulates exam & history bullets to assign a level for these two key components—this works well, but some systems work from 1995 guidelines, others from 1997 guidelines
• Tabulates MDM points when prescriptions written and labs ordered; cannot calculate level of problem acuity status. Requires provider input and CAN BE MANIPULATED!
• Many systems require MDM to be one of the two required elements for an established pt, resulting in erroneous code assignment
“The EMR made me do it!”
# Health Maintenance History

**Doctor Spivey; 5/17/2010 1:25 PM**

**Annual Eye Exam**

No Vision, 10/4/2009

**Review of Systems**

**Doctor Spivey; 5/17/2010 1:25 PM**

**General**
- Present: Feeling well and Good Energy Level
- Not Present: Fever
- Skin: Not Present: Rash
- HEENT: Not Present: Visual Disturbances
- Neck: Not Present: Neck Stiffness
- Respiratory: Not Present: Cough and SOB
- Cardiac: Not Present: Palpitations
- Neurovascular: Not Present: Intermittent
- Gastrointestinal: Not Present: Change in Bowel Habits
- Musculoskeletal: Not Present: Joint Pain
- Neurological: Not Present: Focal Neurological Symptoms and Headaches
- Endocrine: Not Present: Excessive Thirst and Excessive Urination
- Hematology: Not Present: Easy Bruising

**Vitals**

**Doctor Spivey; 5/17/2010 1:25 PM**

<table>
<thead>
<tr>
<th>Item</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Height</td>
<td>5’5”</td>
</tr>
<tr>
<td>Weight</td>
<td>118 lbs</td>
</tr>
<tr>
<td>Body Surface Area</td>
<td>70 sq. ft</td>
</tr>
<tr>
<td>Body Mass Index</td>
<td>26.9 kg/m²</td>
</tr>
<tr>
<td>Pulse</td>
<td>70 bpm</td>
</tr>
<tr>
<td>Respiration</td>
<td>14/min (Rounded)</td>
</tr>
<tr>
<td>BP (systolic)</td>
<td>110/60</td>
</tr>
</tbody>
</table>

**Physical Exam**

**Doctor Spivey; 5/17/2010 1:50 PM**

This physical exam findings are as follows:

**General**
- General Appearance: Cooperate and Well groomed
- Body Build: Normal
- Skin Color: Normal
- Head: Normal
- Neck: Soft

**Chest and Lung Exam**
- Clear and Bronchial Breaths: Quiet, even and easy respiratory effort with no use of accessory muscles and no auscultation, normal breath sounds, no adventitious sounds and normal vocal resonance.

### Cardiovascular

Cardiovascular examination reveals:
- Normal heart sounds, regular rate and rhythm with no murmurs and normal pedal pulses bilaterally.

### Abdominal

- No Masses
- No Distention
- No Drains
- No Bowel Sounds
- Not tender
- No Rubs
- No Bowel Sounds
- No Bruits
- No Clubbing
- No Cyanosis
- No Edema
- No Capillary refill delay

### Peripheral Vascular

- No Clubbing
- No Cyanosis
- No Edema
- No Varicosities
- No Venous Gush

### Neurological

- Normal Motor, Sensory and Reflexes
- No Abnormalities
- No Fasciculations
- No Carpal Tunnel Syndrome

### Renal Evaluation

- No Abnormalities
- No History of Urinary Tract Infection

### Musculoskeletal

- No Swelling
- No Pain
- No Muscle Weakness
- No Muscle wasting

### Lymphatics

- Normal
- No Enlarged Lymph Nodes
- No Axillary Lymph Nodes
- No Occipital Lymph Nodes
- No Cervical Lymph Nodes
- No Epigastric Lymph Nodes
- No Axillarly Nodes
- No Popliteal Lymph Nodes
- No Jugular Lymph Nodes
- No Supraventricular Lymph Nodes

### General Physical Exam

- Normal
- No Lesions
- No Cyst
- No Hemangioma

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**AAPC**

American Academy of Professional Coders
Assessment & Plan

SPRAIN/STRAIN, INTERPHALANGEAL (842.13)

Current Plans
- Advil PRN Pain
- ICE
- APPLICATION OF FINGER SPLINT (29130)

This is a new problem-no additional workup planned.

What the Calculator says
### Compliant

#### New Patient Documentation

<table>
<thead>
<tr>
<th></th>
<th>HPI</th>
<th>ROS</th>
<th>PFSH</th>
<th>PE BULLETS</th>
<th>MDM/TIME</th>
</tr>
</thead>
<tbody>
<tr>
<td>99203</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>12</td>
<td>LC/30</td>
</tr>
<tr>
<td>99204</td>
<td>4</td>
<td>10</td>
<td>3</td>
<td>2 in 9 areas</td>
<td>MC/45</td>
</tr>
<tr>
<td>99205</td>
<td>4</td>
<td>10</td>
<td>3</td>
<td>2 in 9 areas</td>
<td>HC/60</td>
</tr>
</tbody>
</table>

All 3 key components must be met to achieve a level of service for a new patient encounter. The lowest level of any key component dictates the level of service that may be reported. Recall that Moderate Complexity MDM requires any 2 of the following: 3 problem points or management options, 3 data points or moderate risk.

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### Compliant

#### Established Patient Documentation

<table>
<thead>
<tr>
<th></th>
<th>HPI</th>
<th>ROS</th>
<th>PFSH</th>
<th>PE BULLETS</th>
<th>MDM/TIME</th>
</tr>
</thead>
<tbody>
<tr>
<td>99213</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>6-11</td>
<td>LC/15</td>
</tr>
<tr>
<td>99214</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>12+</td>
<td>MC/25</td>
</tr>
<tr>
<td>99215</td>
<td>4</td>
<td>10</td>
<td>3</td>
<td>2 in 9 areas</td>
<td>HC/40</td>
</tr>
</tbody>
</table>

Two of three key components must be met to achieve a level of service for an established patient encounter. Recall that Moderate Complexity MDM requires any 2 of the following: 3 problem points or management options, 3 data points or moderate risk.
Compliant Consultations

• The 3 R’s: Request-Render-Respond
• Even though the consult codes are not reported for Medicare, the 3 components must be present.
• Begin notes with “Dr. Jones has requested my opinion regarding %@#$&%…”
• Wear protective gear when instructing surgeons that ED ‘consults’ may not be consults at all!

Compliant Documentation

• Content
• Scribes
• Transcribing
• Completion
Compliant Content-
The interval history

H&P or HPI?

CC: Frequent falls

HPI: Over the last few months she has been falling. The falls are usually but not always associated with tripping. Upon standing she often becomes dizzy and loses her “equilibrium”. She never has a prodrome of any kind. She feels much better today. She is getting her energy back and has less vertigo now than on admission.

Orthostatics are not revealing, however she has an AUSCULT ORY GAP of some size, that can make orthostatics difficult to accurately obtain. From her history she has a subjective vertigo that is prompted by movement especially rising in the am. She can regain her balance by simply touching anything secured and often reflexively touches the wall to maintain balance.

My bet is that she is suffering from several types of “Dizziness”: true vertigo, ortho ataxia, mix-sensory input failure, posterior circulation compromise, and mild ataxia. Her rhomberg’s is difficult due to her unsteadiness. Will check B12 as she has some decreased posterior column responses.

The Next Encounter-
The Pull-Forward

CC: Frequent falls

HPI: Over the last few months she has been falling. The falls are usually but not always associated with tripping. Upon standing she often becomes dizzy and loses her “equilibrium”. She never has a prodrome of any kind. She feels much better today. She is getting her energy back and has less vertigo now than on admission.

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The Next Day: Copy & Paste

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HPI: Over the last few months she has been falling. The falls are usually but not always associated with tripping. Upon standing she often becomes dizzy and loses her "equilibrium". She never has a prodrome of any kind. She feels much better today. She is getting her energy back and has less vertigo now than on admission. Orthostatics are not revealing, however she has an AUSCULT ORY GAP of some size, that can make orthostatics difficult to accurately obtain. From her history she has a subjective vertigo that is prompted by movement especially rising in the am. She can regain her balance by simply touching anything secured and often reflexively touches the wall to maintain balance.
My bet is that she is suffering from several types of "Dizziness": true vertigo, ortho stasis, mix-sensory input failure, posterior circulation compromise, and mild ataxia. Her rhombeng's is difficult due to her unsteadiness. Will check B12 as she has some decreased posterior column responses.

This is not compliant - there is no new information and therefore the medical necessity of the encounter is in question.

AAPC

The Next Encounter - The Copy & Paste, Paste

CC: Frequent falls
HPI: Over the last few months she has been falling. The falls are usually but not always associated with tripping. Upon standing she often becomes dizzy and loses her "equilibrium". She never has a prodrome of any kind. She feels much better today. She is getting her energy back and has less vertigo now than on admission. Orthostatics are not revealing, however she has an AUSCULT ORY GAP of some size, that can make orthostatics difficult to accurately obtain. From her history she has a subjective vertigo that is prompted by movement especially rising in the am. She can regain her balance by simply touching anything secured and often reflexively touches the wall to maintain balance.
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AGAIN??!! THIS LOOKS PRETTY BAD...
The Pull Forward & Copy/Paste

- With the second encounter, adding to the previous note helped set the stage for the day’s encounter, but this was diminished by the 3rd encounter that was an exact replica.
- The credibility of this record is now in question, and the coder may not consider this duplicated information in determining the level of service.
- The more alike progress notes appear, there is higher likelihood of contradictory information in the note which may endanger reimbursement.

Compliant Copy & Paste—Really?

- The chief complaint or the interval history is the key to establishing the medical necessity of each encounter.
- Critical data is the main issue in the cloned record. The patient’s complaints/exam are likely to change from day to day and this must be reflected in the note.
- So are these entries compliant? They can be if it is clear in the documentation that provider work occurred during a face to face encounter.
Using the same template repeatedly sheds doubt on the credibility of the record

### Scribing or Transcribing?

- Scribes are health professionals present during face to face patient encounters with the provider.
- Transcriptionists are professionals that prepare an exact record of patient data dictated or otherwise communicated by a physician.
Scribes

- Use of scribes can speed documentation in the EMR and are used extensively in the ED & inpatient setting. Becoming more popular in the ambulatory setting as EMRs penetrating the outpatient arena
- Recommend that scribes are health professionals
- Must be present during face to face encounter, and must make a third-person reference in the record that indicates they are scribing while the billing providers is performing the service, and must authenticate note with name and discipline. “Scribed by [name, credentials], present with Dr. Jones during this encounter.”
- Physicians utilizing scribes must make reference to the scribe as well: “The above service was scribed by [name, credentials] on my behalf and I attest to the accuracy of the note.”
- Recommend having policy & procedure before going live on EMR!

Compliant Transcribing

- Typically thought to mean transforming a dictation into written form-compliant when performed by a professional-as from the Association for Healthcare Documentation Integrity (AHDI)
- Growing use for transforming written notes into the EMR
  - Must be an exact copy
  - Scan original document into EMR
  - Recommend use of health professionals
- Recommend having policy & procedure before going live on EMR!
Compliant Electronic Signatures

• “Electronically signed by” with provider’s name.
• Signature log must be on file

Closing Encounters

• May need to update policy when EMR is implemented at your institution
• Recommend language that references the specific EMR-related areas of concern
  – Pre-loading of historical data
  – Patient checked in and not seen (provider must go to ED)
  – Dictation
  – Closing/signing off/locking encounters
Thank You!

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