Common Issues in the Documentation of Services

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Objectives

- Review the required documentation elements for Evaluation and Management services
- Learn the appropriate way to document and code compliantly based on time
- Review and identify the conditions that require specificity for location, laterality and acuity of conditions
- Discuss when it is appropriate or not appropriate to include conditions from the active problem list in the assessment, or to report them on a claim

Evaluation & Management Issues

- Chief Complaint
  - Required for all E/M services
  - Clear and concise
- Family History
  - "Non-contributory" requires elaboration
- Review of systems
  - Statements stating the remaining systems were reviewed and negative are only supported where there is evidence of the systems reviewed

Evaluation & Management Issues

- Comprehensive Exam 95 Guidelines
  - Eight organ systems are required, body areas are not counted
    - Body Areas:
      - Head, including the face
      - Neck
      - Chest, including breasts and axillae
      - Abdomen
      - Genitalia, groin, buttocks
      - Back, including spine
      - Each extremity
    - Single system exams only defined by 97 specialty exam guidelines

Evaluation & Management Issues

- Active Problem List
  - Pulled into the assessment when the conditions are not managed by or documented as being the reason for the service
- Assessment
  - Diagnosis listed without status provided
  - Diagnosis not supported by the documentation
- Medical Decision Making
  - Evidence of direct visualization of an image, tracing or specimen with interpretation must be clearly indicated
  - Stating images are reviewed without summary is counted only as a review

Counseling & Coordination of Care

- Office is face-to-face time with total time and counseling/coordinaton of time listed.
  - Spent 25 of the 40 minutes counseling the patient regarding the abnormal lab results as outlined in the plan. (Estab Pt 99215)
- Hospital is unit-floor time with total time and counseling/coordinaton of time listed.
  - 45 of the 50 minutes spent on the patient's case were spent explaining the CT findings to the patient and coordinating care with the neurosurgeon and consulting cardiology. (Inpatient Initial 99222)
- KEY – Description of the counseling and/or coordination of care activities must be documented.

Prolonged Services

- Only the time spent by the physician providing the face-to-face service
- Start and end times must be documented
- The time does not need to be contiguous
- When counseling and/or coordination of care is the basis for the prolonged service, only report prolonged services with the highest code level in that family of codes as the companion code.

- https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/mm5972.pdf

ICD-10-CM Injuries

INJURIES

Increased Specificity

ICD-9 used separate "E codes" to record external causes of injury. ICD-10 better incorporates these codes and expands sections on poisonings and toxins.

When documenting injuries, include the following:

1. Episode of Care	e.g. Initial, subsequent, sequelae
2. Injury site	Be as specific as possible
3. Etiology	How was the injury sustained (e.g. sports, motor vehicle crash, pedestrian, slip and fall, environmental exposure, etc.)?
4. Place of Occurrence	e.g. School, work, etc.

Initial encounters may also require, where appropriate:

1. Intent	e.g. Unintentional or accidental, self-harm, etc.
2. Status	e.g. Civilian, military, etc.

Example 1:

A left knee strain injury that occurred on a private recreational playground when a child landed incorrectly from a trampoline:

- **Injury:** S86.812A, Strain of other muscle(s) and tendon(s) at lower leg level, left leg, initial encounter
- **External cause:** W09.8xxA, Fall on or from other playground equipment, initial encounter
- **Place of occurrence:** Y92.838, Other recreation area as the place of occurrence of the external cause
- **Activity:** Y93.44, Activities involving rhythmic movement, trampoline jumping

Example 2:

On October 31st, Kelly was seen in the ER for shoulder pain and X-rays indicated there was a fracture of the right clavicle, shaft. She returned three months later with complaints of continuing pain. X-rays indicated a nonunion. The second encounter for the right clavicle fracture is coded as *S42.021K, Displaced fracture of the shaft of right clavicle, subsequent for fracture with nonunion.*

ICD-10-CN Acute Myocardial Infarct

ACUTE MYOCARDIAL INFARCTION (AMI)

Definition Change

When documenting an AMI, include the following:

1. Timeframe	An AMI is now considered "acute" for 4 weeks from the time of the incident.
2. Episode of care	ICD-10 does not capture episode of care (e.g. initial, subsequent, sequelae).
3. Subsequent AMI	ICD-10 allows coding of a new MI that occurs during the 4 week "acute period" of the original AMI.

I21.02	ST elevation (STEMI) myocardial infarction involving left anterior descending coronary artery
I21.4	Non-ST elevation (NSTEMI) myocardial infarction
I22.1	Subsequent ST elevation (STEMI) myocardial infarction

ICD-10-CM Asthma

ASTHMA

Terminology Difference

ICD-10 terminology used to describe asthma has been updated to reflect the current clinical classification system.

When documenting asthma, include the following:

1. Cause	Exercise induced, cough variant, related to smoking, chemical or particulate cause, occupational
2. Severity	Choose one of the three options below for persistent asthma patients 1. Mild persistent 2. Moderate persistent 3. Severe persistent
3. Temporal Factors	Acute, chronic, intermittent, persistent, status asthmaticus, acute exacerbation

J45.30	Mild persistent asthma, uncomplicated
J45.991	Cough variant asthma

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ICD-10-CM Underdosing

UNDERDOSING

Terminology Difference

Underdosing is an important new concept and term in ICD-10. It allows you to identify when a patient is taking less of a medication than is prescribed.

When documenting underdosing, include the following:

1. Intentional, Unintentional,Non-compliance	Is the underdosing deliberate? (e.g., patient refusal)
2. Reason	Why is the patient not taking the medication? (e.g.financial hardship, age-related debility)

Z91.120	Patient's intentional underdosing of medication regimen due to financial hardship
T36.4x6A	Underdosing of tetracyclines, initial encounter
T45.526D	Underdosing of antithrombotic drugs, subsequent encounter

ICD-10-CM Diabetes

DIABETES MELLITUS, HYPOGLYCEMIA AND HYPERGLYCEMIA

Increased Specificity

The diabetes mellitus codes are combination codes that include the type of diabetes mellitus, the body system affected, and the complications affecting that body system.

When documenting diabetes, include the following:

1. Type	e.g. Type 1 or Type 2 disease, drug or chemical induced, due to underlying condition, gestational
2. Complications	What (if any) other body systems are affected by the diabetes condition? e.g. Foot ulcer related to diabetes mellitus
3. Treatment	Is the patient on insulin?

A second important change is the concept of "hypoglycemia" and "hyperglycemia." It is now possible to document and code for these conditions without using "diabetes mellitus." You can also specify if the condition is due to a procedure or other cause.

The final important change is that the concept of "secondary diabetes mellitus" is no longer used; instead, there are specific secondary options.

ICD-10-CM Tobacco

- Cardiovascular, Cerebrovascular and Pulmonary sections

Use additional code to identify:
exposure to environmental tobacco smoke (Z77.22) (Z77.22)
history of tobacco use (Z87.891) (Z87.891)
occupational exposure to environmental tobacco smoke (Z57.31) (Z57.31)
tobacco dependence (F17.-) (F17)
tobacco use (Z72.0) (Z72.0)

ICD-10-CM Obesity

- BMI is to be reported with overweight and obesity

E66 Overweight and obesity

Code first obesity complicating pregnancy, childbirth and the puerperium, if applicable (O99.21-) (O99.21)

Use additional code to identify body mass index (BMI), if known (Z68.-) (Z68)

ICD-10-CM Specialty Resources

Clinical Concepts Series

Guides include common ICD-10 codes, clinical documentation tips, clinical scenarios, and links to Road to 10 by specialty:

- Family Practice
- Internal Medicine
- Cardiology
- OB/GYN
- Orthopedics
- Pediatrics

https://www.cms.gov/Medicare/Coding/ICD10/ProviderResources.html

M.E.A.T

- **M**-monitoring – signs, symptoms, disease progression, disease regression
- **E**-evaluating – test results, medication effectiveness, response to treatment
- **A**-assessing/addressing – ordering tests, discussion, review records, counseling
- **T**-treatment – medications, therapies, other modalities

Diagnosis Reporting Outpatient Service

- First listed diagnosis
  - Chief complaint, reason for encounter
- Chronic diseases
  - Only when treatment and care are documented during the encounter
- Coexisting conditions
  - Are reported when the coexisting condition require or affect patient care treatment or management

QUESTIONS

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