Good E/M Documentation
a Win-Win for Physicians
and CDI Specialists

Know the required elements for physician billing to help achieve buy-in

The lifeblood of a physician is not his or her profile, quality scores, or the hospital’s DRG payment. It’s the physician’s own pocketbook—i.e., the E/M codes he or she reports.

Good documentation is integral to the business of a physician’s practice. CDI specialists should think of themselves as the physician’s partners in business and be their eyes and ears in the medical record, says Glenn Krauss, RHIA, CCS, CCS-P, CPUR, FCS, PCS, CCDS, C-CDI, manager of CDI services at YPRO Corporation in Indianapolis and a member of the ACDIS advisory board. Although Stark inducement laws prohibit CDI specialists from telling physicians how to bill, they can and should prompt physicians to provide good documentation in the record to support their billing, Krauss says.

Many physicians report their own E/M codes simply by circling what they feel is the most appropriate level, often on a pocket card or electronic handheld device. But this can lead to countless billing errors and take-backs from Comprehensive Error Rate Testing contractors and Medicare administrative contractors. That’s because many physicians don’t understand the three components that go into determining E/M levels and the documentation needed to support them.

Unless he or she has access to a computerized record, a physician typically does not document during patient interactions. Instead, he or she will document the encounter long afterward. A typical encounter between a physician and a patient might include the physician evaluating labs, speaking to a nurse, going to see the patient, assessing the patient, then documenting later on. There is the potential for much to be missed during this process, says Krauss.

“Physicians don’t take shortcuts in their practice of medicine, and they ask the patients these questions [regarding their medical history, etc.], but the fact of the matter is that they don’t always actually document what they’ve asked,” Krauss says. He recommends that CDI specialists familiarize themselves with physician E/M billing. They should also review records with an eye on ensuring documentation of the three components of an E/M code. “A CDI specialist should be able to talk to the physician about these issues in an intelligent fashion,” he says.

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CDI specialists can use a free document published by Medicare Part B contractor Highmark Medicare Services, *Highmark Medicare Services Documentation Worksheet* (https://www.highmarkmedicareservices.com/partb/reference/pdf/scoresheets/8985.pdf), to educate themselves on physician E/M. The following breaks down the worksheet and provides guidance that CDI specialists can use to educate physicians on improving their documentation.

**The basics of E/M**

You can find a complete listing of the different types of E/M codes physicians must use to bill for their professional services in the front section of the *CPT Manual*, published by the AMA.

Just like ICD-9-CM codes, all E/M codes have specific documentation requirements. There are three components to an E/M code:

1. History
2. Physical exam
3. Medical decision-making

You can determine final E/M code assignment for a given encounter by using the *Highmark Medicare Services Documentation Worksheet*. It provides documentation requirements for each of these three elements and easy-to-use tables on how to quantify the type of history, physical examination, and medical decision-making performed by the physician.

Section five of the worksheet, Level of service, allows a reviewer to plug in these three categories and determine the final E/M code that should be reported for the encounter.

Below is a detailed explanation of the three elements and how the CDI specialist can improve documentation of each.

**History**

History is broken out into the following four components (see section 1 of the *Highmark Medicare Services Documentation Worksheet*):

1. Chief complaint
2. History of present illness
3. Review of systems
4. Past medical, family, and social history

When reviewing the H&P, take an extra moment to review the extent of the patient’s history of present illness (HPI). This documentation also helps justify inpatient admissions, since the severity of signs and symptoms and the acuity of the patient provides auditors with evidence of a higher probability of an adverse reaction or an untoward event.

Many CDI specialists make the mistake of jumping right into the reported diagnoses, or in some cases the physical exam, while ignoring the HPI. The HPI
A physician should strive to document at least four of these eight elements of the HPI, provided that they are clinically pertinent.

should incorporate the clinically relevant elements related to the patient’s chief complaint, since these elements help paint a picture of medical necessity. On the Highmark Medicare Services Documentation Worksheet, there are eight of these elements: location, severity, quality, associated signs or symptoms, duration, timing, contact, and modifying factors.

A physician should strive to document at least four of these eight elements of the HPI, provided that they are clinically pertinent. If he or she only documents three elements—even if he or she documents a complete review of systems—the highest level the physician can achieve in this column of the worksheet is expanded problem-focused. If, during an initial hospitalization visit, a physician documents a comprehensive exam and high complexity of medical decision-making but only an expanded problem-focused HPI, he or she can only bill for a subsequent E/M visit code, which provides far less reimbursement for the physician despite the amount of work performed as part of the H&P. “The physician’s time and work with the patient is not reflected and goes unrewarded,” Krauss says.

Physical exam

The physical exam portion of an E/M level is broken out into the following four levels (see section 2 of the Highmark Medicare Services Documentation Worksheet):

1. Problem-focused exam
2. Expanded problem-focused exam
3. Detailed exam
4. Comprehensive exam

A problem-focused exam includes documentation that the physician reviewed one body area or organ system. A physician must document two to seven body systems to achieve an expanded problem-focused exam.

Reviewing and documenting seven body systems will yield a detailed exam, provided that the physician has documented at least four comments on at least four body systems (aka “the rule of 4x4”). For example, if a physician documents only “ears clear,” it does not count as documentation toward a detailed exam. However, if he or she documents “no drainage, no exudates, ears clear, and no red tissue,” that would count.

To help physicians with their documentation of their physical exam, encourage them to include this level of detail in their H&P (when clinically appropriate).

Medical decision-making

Medical decision-making comprises the following three elements (see section 3 of the Highmark Medicare Services Documentation Worksheet):

1. Number of diagnoses or treatment options
2. Amount and/or complexity of data reviewed
3. Risk of complications and/or morbidity or mortality
Once you’ve added up these numbers, you arrive at the type of decision-making: straightforward, low complexity, moderate complexity, or high complexity. See the “Final Result for Complexity” table in section 3 of the Highmark Medicare Services Documentation Worksheet.

Remind physicians that listing stable, chronic conditions is mostly limited to fulfilling the requirements of the past history part of the history component of the E/M service (see section 1 of the worksheet). For example, if a physician documents in his or her assessment “acute episode of chest tightness with worsening CAD, hyperlipidemia, hyperthyroidism, osteoarthritis, asthma, hypercalcemia,” the only diagnosis the physician is actively managing is the acute episode of chest tightness (CAD).

“The physician can only count the CAD diagnosis [under the number of diagnoses or treatment options section of medical decision-making] since the other diagnoses documented do not directly impact upon the physician’s medical management and medical decision-making,” Krauss says.

To aid his or her documentation of medical necessity, ask the physician to document his or her concerns with the patient’s diagnoses in the record. For example, is the patient’s CAD stable or unstable? Is the patient’s angina stable or unstable? Is there clinical concern for a myocardial infarction (MI)? Ask the doctor, “What are your thoughts on this chest pain? I see that the patient rested and the pain didn’t go away—is it unstable angina? Or can you not determine a diagnosis at this time?”

If the physician reports an established problem that is getting worse—for example, a patient with worsening angina or unstable CAD—the condition is counted as two points in the “Number of Diagnoses or Treatment Options” table. If the physician documents a new problem that will require additional workup, such as a possible MI, it’s worth four points.

The “Amount and/or Complexity of Data Reviewed” table is self-explanatory. For example, consider a patient who presents with pneumonia. The physician orders an initial chest x-ray, CT scan, and labs, documenting all of these elements in the record. The result is an assignment of three points according to the table.

The physician in these examples is simply documenting what he or she is thinking and evaluating regarding the patient. Encourage the physician to document all the conditions that he or she is managing. If a physician orders new tests or changes medication, he or she should count these in the medical decision-making.

For example, if a patient has diabetes and the physician orders a steroid for exacerbation of Crohn’s disease that contributes to subsequent labile glucose levels, requiring the ordering and administration of IV insulin, this would
count toward the physician’s medical decision-making (steroids can throw the patient’s diabetes out of control).

Ask the physician to include his or her plan of care and orders in each day’s progress note in conjunction with the diagnoses currently being managed. Why? If an outside reviewer requests a hospital progress note to validate a billed E/M level, the physician orders are typically not sent with the progress note. This can lead to potential downcoding of the E/M level on the basis of a lesser level of medical decision-making.

Risk of complications and/or morbidity or mortality is presented in the Highmark Medicare Services Documentation Worksheet as a table of risk, with presenting problem(s), diagnostic procedure(s) ordered, and management options selected across the top, and level of risk (minimal, low, moderate, high) in the left-hand column.

Note that high-risk presenting problems are those diagnoses for which CDI specialists often leave a query, such as acute MI and acute renal failure. Other diagnoses listed here are often prompts for queries (e.g., severe respiratory distress to determine whether the patient has respiratory failure).

**Quality, not quantity**

A common conception among physicians is that quantity of documentation is all that’s needed to report high-level E/M codes. This notion is false. Some physicians will provide paragraphs of excellent documentation in their H&P, but miss a few key elements that prohibit them from legitimately billing a high-level E/M code. The following is an example:

A patient presented with acute respiratory failure and pneumonia. The physician on her physical exam performed all the work required of a level 3 E/M code (99223), but only documented a review of seven systems instead of eight (she didn’t write down her review of the patient’s neurological status).

As a result, the code was downgraded to a 99221, and the physician lost $100 in reimbursement, to which she was ethically entitled based upon the severity of the patient’s illness, the amount and complexity of medical decision-making, and the work performed.

Why did this occur? Code 99223 requires a comprehensive history, a comprehensive exam, and high-complexity medical decision-making. The physician only reported an extended review of systems (2–9), leading to a “detailed” rather than a “complete” history.

**A win-win situation**

Documentation to support E/M billing has the side benefit of helping the CDI specialist and the hospital. For example, the number of diagnoses a physician reports reflects the complexity of his or her medical decision-making.
it also helps CDI specialists get the documentation they need to support final DRG assignment.

CDI specialists can help physicians and the hospital by asking the physician to document these diagnoses throughout the record. Outside auditors typically ask for a given day in which the E/M code was reported; therefore, the physician cannot rely on having documented the diagnosis the previous day. Every day must stand on its own.

Doctors might not respond to a request to write down a diagnosis every day, so tell them, “no chief complaint, no diagnosis, no E/M.”

Getting a more specified diagnosis also benefits the hospital; it’s a win-win for both the hospital and the physician.

For example, an acute illness with systemic symptoms (e.g., pneumonitis) only counts as moderate risk, whereas an acute or chronic illness with severe exacerbation or progression counts as a high risk.

When CDI specialists get in the habit of reviewing medical records for overall documentation and support for E/M codes, it prevents the chronic problems associated with reviewing medical records for diagnoses only.

Without supporting documentation for diagnoses, including signs and symptoms, nursing documentation, and acuity, a recovery audit contractor could downcode a DRG assignment based on a lack of clinical evidence of the diagnosis in the record.

Case study
The following case study demonstrates how to assign an E/M level and how improved documentation can have an effect on the final E/M assignment.

Chief Complaint: Phyllis is a 71-year-old female who presented to the ER last night with complaints of chest pain. The chest pain was an 8 on a scale of 1 to 10. She also had some complaints of shortness of breath.

HPI: The patient is a 71-year-old female with a history of coronary artery disease; she was seen approximately one week ago with complaints of intermittent chest pain or tight sensation with activity. We were currently in the middle of a cardiac workup, where she was scheduled for a stress test. The patient developed some pain last night that was not alleviated with rest, so she presented to the ER.

Past surgical history: Cardiac stents in 2003. History of cholecystectomy, appendectomy, hysterectomy, C-section x3, cataract removal, and colonoscopy and upper endoscopy approximately 3 weeks ago.

Allergies:

Medications: Aspirin 81 mg daily, Pepcid 20 mg b.i.d., Synthroid 100 mcg daily, Singular 10 mg daily, Zetia 10 mg daily, Toprol 50 mg per day, Lasix 40 mg daily, Mirapex 0.125 mg po at hs, multivitamin, Calcium 600 mg with D b.i.d. She also takes Crestor 10 mg daily, Flovent 110 mcg 2 puffs b.i.d., Osteo B-Flex, and CoEnzyme CQ-10.

Social history: Currently retired; resides with spouse. She is a nonsmoker, nondrinker, and does not take illicit drugs.

Review of symptoms: Patient has occasional headaches that resolve with Motrin. Some nasal congestion secondary to allergic rhinitis. Patient has intermittent episodes of shortness of breath with activity and occasional wheezing with exacerbation of her asthma. Patient complains of intermittent chest tightness. She was not relieved with Nitro. She did have some relief with aspirin. Occasional constipation and occasional reflux symptoms. GU with no complaints. Neurological with no complaints.

Physical examination:

General appearance: Patient is an elderly female resting in bed in no acute distress.

Vital signs:


Lungs: Good aeration and clear with a faint expiratory wheeze.

Heart: Regular rate and rhythm without murmurs, gallops, or rubs.

Abdomen: Soft and nontender. Bowel sounds are normoactive. Negative splenomegaly.

Extremities: Negative for cyanosis, clubbing, or edema. No rashes or lesions.

Neurologic: Patient’s affect is appropriate to situation.

Plan: The patient was admitted. Cardiac enzymes were ordered. Patient will be monitored.

How would this case be leveled?

History
The case meets criteria for extended history of present illness (quality is reflected in the pain scale) and there is also documentation of location (chest pain), signs and symptoms (shortness of breath), duration (one week), and timing (intermittent). Past medical, family, and social history is also documented, leading to an assignment of complete.

However, review of systems only counts as extended. The physician has provided documentation of the following elements: constitutional; neurological (headache); ears, nose, and throat; respiratory (shortness of breath); musculoskeletal (chest tightness); GI (constipation); and GU. The physician’s failure to document allergies hurts the review of systems, as even documenting “review of allergies, not contributory” would count as a point.

Final assignment: Detailed. Why? The column containing a circle farthest to the left must be circled, according to the directions.

Examination
The documentation includes examination of the following elements: constitutional (general appearance); ears, nose, and throat; eyes; lungs; heart; abdomen; extremities; and neurologic.

Final assignment: Comprehensive. Why? Eight systems are documented.

Medical decision-making
Under number of diagnoses or treatment options, the patient’s chest tightness is worth four points (new problem with further workup).

Under amount and/or complexity of data reviewed, the physician only documented an order of cardiac enzymes (one point).

On the table of risk, the physician documents moderate medical decision-making (the patient has no life-threatening condition). CAD falls into the category of one or more chronic illnesses with mild exacerbation.

Final assignment: Moderate complexity.

Final coding
The physician must report a level one initial hospital/observation E/M code for the above encounter (D/C on the history, C on examination, M on complexity of medical decision-making). The code assignment is 99221.
However, improved documentation along the way could have made a big difference.

For example, regarding history, if the physician had documented that he or she reviewed the patient’s allergies and documented “all other systems negative,” the exam would have been comprehensive instead of detailed.

Additionally, had the physician instead documented “acute episode of chest tightness, unstable angina, real concern for MI,” and documented the known risk factors, the physician’s medical decision-making could have been high instead of moderate since the patient’s condition would then be considered life-threatening. The CDI specialist could have left an appropriate query for unstable angina due to the patient’s chest pain of 8 out of 10, which was not relieved by rest.

This improved documentation would have resulted in comprehensive history, comprehensive examination, and high medical decision-making, which supports a level three initial hospital/observation code—99223. The documentation would also have better reflected the clinical picture and severity of the patient.

Editor’s note: You can find the Highmark Medicare Services Documentation Worksheet at the following URL: https://www.highmarkmedicareservices.com/partb/reference/pdf/scoresheets/8985.pdf.

You can find an electronic E/M leveling tool at the First Coast Service Options website: http://medicare.fcso.com/EM/165590.asp.