Documentation Tips

Office and Other Outpatient E/M Codes

American Academy of Child & Adolescent Psychiatry
www.aacap.org

MAIN CHANGES

- Provider's option whether to select the code based on medical decision making (MDM) or total time across the calendar day.
- Documentation of history and examination is still required! This is required to the extent that is medically indicated for the patient, condition, and situation, but there are no required bullets and the extent of history and exam documented does not change the level of the code.
- A primary purpose of the changes is to reduce administrative burden (read: get rid of note bloat!).
    - Past labs should only be included when directly relevant to the work of the current encounter.
    - Most or all of review of systems and past, family, social history should be included in HPI, and also only when directly relevant.
- The changes only apply to office and other outpatient E/M codes. All other E/M codes have the criteria that they have always had.

TIME

- Use total time across the calendar day of the encounter. Time spent before or after that day is built-in to the code valuation but does not give you any time credit.
- Specify what you did. See E/M Summary Guide for list of allowed activities.
- To the extent you did psychotherapy, use a psychotherapy add-on code (with documentation of time doing psychotherapy) and select the E/M code based on *MDM*.

MEDICAL DECISION MAKING

- Use language that may be easily inferred to support the criteria that you used to choose the code.
- It would not hurt to overtly state which criteria those are (for psychiatrists, generally one from the problems column and one from the risk column).
- State "chronic" when chronic.
- State "severe" when severe (now or recently).
- State which symptoms are "systemic" when using "acute illness with systemic symptoms" or "acute illness that poses a threat to life or bodily function."
- "Exacerbation, progression, or side effects" should be easily inferred.
- "Undiagnosed new problem with uncertain prognosis": state additional work up or information needed to "diagnose" and the problem in the differential diagnosis that is likely to result in high risk of morbidity without treatment.
- "Prescription drug management": this refers to the management, not the writing of scripts, and may include when medications are considered as part of shared medical decision making and not prescribed.
    - It may be helpful to state: "Reviewed medication efficacy, possible/potential side effects, and patient/family preferences. Based on shared medical decision making, the plan for prescription drug management is as stated below."
- A key part of "decision for hospitalization" is the word "decision." Sending a patient to the ED for evaluation for admission does NOT meet this criterion, because it is the ED staff and not you making the decision. Document the shared medical decision making (by you and patient/family) and the resultant decision for admission. It is not needed that the patient eventually actually gets admitted.
    - It is also not needed that the decision is *for* admission – this criterion is met based on the decision *process*.
    - Helpful wording should hospitalization be *realistically considered today* and decided against: "Reviewed indication(s) for hospitalization: ____. Based on shared medical decision making, including a good safety plan, the decision for hospitalization is to not admit. Discussed that, if there is a future concern or change in status, patient/family will call this provider or 911 or go to the hospital."
- "Drug therapy requiring intensive monitoring for toxicity" needs all the elements. See E/M Summary Guide Appendix.

Principles

Based on Recommendations from CMS[1]

IF IT WAS NOT DOCUMENTED, IT WAS NOT DONE!!!!!

The medical record (chart) serves as the official chronological record of the patient's treatment and includes the facts, findings, assessment, and treatment that the patient received. It is necessary for treatment providers who are involved in the patient's care, medical payors who need to ascertain that the services billed for were done. The medical record should be complete and legible. In situations of alleged malpractice, this record serves as the proof of the care that was provided to the patient.

The new E/M code criteria were developed to address the excessive burden of documentation and the resulting chart bloat that occurred with the previous codes, especially since the adoption of the EMR.

Documentation for each patient visit should include:

- Date
- Person(s) present or other sources of information used for this encounter
- Reason for visit
- History and exam that is "medically indicated" to support the medical decision making and treatment recommendations
- Review of any reports or test results since the last visit that are pertinent to visit
- Diagnosis(es) that was (were) addressed, including identification of any new problems or diagnoses that emerged
- Documentation of rationale for current treatment, changes to treatment plan and plan for additional testing or referral
- Documentation of any health risk, psychosocial or behavioral issues that impact treatment

The factors that justify the level of MDM for code selection must be clearly stated.

All visit notes should have the diagnoses and/or problems clearly visible, and note the severity, onset and chronicity or acuteness of the problems. *A reader should be able to easily infer what data and problems addressed apply to today's visit.*

[1] Department of Health and Human Services, Center for Medicare and Medicaid Services: Evaluation and Management Services Guide; Nov 2014