

## **Easing the Burden of E&M Coding and Documentation**

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To comply with the HCFA documentation requirements for evaluation and management (E&M) coding and to better document patient visits, our group decided to evaluate our medical records. Prior to this self-evaluation, we had established a compliance program as recommended by the Office of the Inspector General (OIG).

The practice I joined is a privately owned three-physician group. Because the physicians have been out of residency for a long time, the documentation did not meet the present standard. To improve our documentation, we explored several methods. Being a small practice, we were concerned with the cost issue, and for this reason did not opt for electronic medical records or dictation. Instead, we have developed a progress note that allows us to improve documentation without incurring too much additional cost. The progress note is also designed in a way that a physician will not be consumed by the time required to complete the patient visit.

Another change we made to reduce cost while increasing compliance was to train our staff to do coding. In the past, the coding was performed solely by physicians who were behind on the latest guidelines and were too busy to completely review every chart for compliance. While we still have room for improvement in our documentation, these changes have greatly improved our rates of compliance. Our staff enjoys the ability to be more active and we have been able to keep costs to a minimum.

The progress note has been widely accepted in our practice and we would like to share it with others who may be struggling, as we were, to document and code in an increasingly demanding practice environment. Some of the features of our document include:

- **Chief Complaint and History:** This area corresponds to the history bullets required by the 1997 guidelines. Our first version of the form did not have the bullets (or the three chronic problems) listed, but we found this helpful for our staff to identify bullets and check our coding accuracy. Also, as our medical assistants obtain a chief complaint, many of these bullets are identified. We simply write the corresponding information next to the bullet point being satisfied. There is plenty of room left for additional history that is vital to the visit, but not helpful for coding.
- **Review of Systems:** This is not an exhaustive list, but we found these to be the most common review of systems questions asked by our physicians. As the instructions indicate, positive reviews are circled and negatives are crossed out. A physician can rapidly obtain a high level of coding and document many additional points with minimal writing.
- **Past, Family and Social History:** When these are checked, you are telling a potential auditor that you have reviewed this information. We found in our own practice that these areas were often not documented, even when we were well aware of the history due to a long-standing relationship with the patient. This caused the visit to be down-

coded.

- **Physical examination:** This raised the largest debate as our form evolved. We elected to keep the bullets exactly as they are in the 1997 documentation guidelines so there would not be any debate during the coding process. Any additional exam pieces not easily documented can be written in the spaces provided. The physical exam was the area where we consistently under documented because of the amount of writing required. Now, a complete exam can be documented in seconds.
- The areas for **Assessment & Plan, Follow up, and Educational Material Given** should be obvious, but we placed them on the chart to remind the physicians to be thorough in their documentation and for improved organization of the progress note. The **Health Maintenance** area is another reminder to physicians to ask about and document health maintenance and preventive medicine issues, even when they were not the focus of the visit.
- Finally, our practice does not have a super bill for each encounter; instead we place all of our charges in the bottom right corner. This keeps the code with the visit and saves on paper and money associated with the printing of super bills.

Of course, there were challenges in implementing this progress note. The evolution took some time and a lot of compromise to develop a tool with which everybody felt comfortable. Also, educating physicians and staff about the need for a new documentation system can be a challenge. Finally, this system does use more paper than old one-line notes, but they are almost as easy to use and greatly increase compliance and communication.

Overall, I believe the new progress note has enhanced our practice. We have learned that we were documenting too little and thus, frequently, under-coding visits. While we do not have numbers to show the financial impact on our practice, we estimate that this simple documentation device will dramatically increase our coding (legally) with minimal extra work on our physicians and staff. As a result of this general progress note, we have also developed progress notes for well woman exams and well child exams (up to eighteen months of age) that we will be happy to share with your practice.

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