

MPECS July 2007 PRODUCTIVE PROVIDER Newsletter

By Jim Meeks, PA-C

July 2007 • Volume 5, Number 3 • © MPECS 2007

MARK YOUR CALENDARS

EVALUATION and MANAGEMENT CODING ESSENTIALS WORKSHOPS & LECTURES:

Jim Meeks, PA-C is dedicated to making your practice of medicine more productive, more profitable and ultimately more enjoyable. The comprehensive MPECS 4-hour **E/M CODING ESSENTIALS** workshop focuses on exactly what you need to know, the specifics of documentation and coding. If you ever find yourself questioning which E/M code you should use, you need this workshop!

MPECS workshops and lectures are now being scheduled;

UP-COMING MPECS WORKSHOPS;

Lehi, Utah

September 15, 2007

Las Vegas, Nevada

November 3, 2007

Orlando, Florida

March 14, 2008

See the **EVENTS** page on the MPECS web site for details and registration information.

CONFERENCE LECTURES;

AFPPA Conf. Las Vegas, NV

October 31, 2007

Available for 2007 - 2008 bookings. Contact me at PracticeProfitability@mpecs.org

Don't Forget The Basics

What happens when you change employment or take on a new clinical site? Be it changing practice sites or clinical rotations, joining a new practice, opening a new office or getting your first job, there will always be the need for some kind of adjustment. Chances are, you will find that **charting** and **documentation** systems are **different** wherever you go. You will find stark contrasts between hand written charts, pre-printed forms, dictation and electronic health records (EHR) or electronic medical records (EMR).

All forms of documentation are based on a set of **BASIC** rules or guidelines. These have been established for some time, but we sometimes forget some of the basic elements and get lost when switching from one form of documentation to another.

Occasionally, I receive inquiries from providers or office managers about what documentation is needed in various settings. A number of years ago, I was asked to explain the documentation rules for pediatrics. The office manager asking the question, told me that he had been unable to find anyone that could outline the requirements for pediatric documentation. When I explained that the documentation requirements for pediatrics were the same as for any other type of patient, there was a long pause and then an expression of frustration and almost disbelief.

The concept of BASIC rules carries over to every kind of practice setting. The rules are the same. Some of the information gathered and documented may be more specific to a particular setting, but the **basic elements** of documentation will all be the **same**.

Remember, a **medical record** is a tool of communication. When one provider sees a patient and documents that encounter, there should be **enough information** in the chart note about that encounter to allow someone else reading that note to be able to understand what the presenting problem was, what was done and what the patient was expected to do.

Standardization of medical records is a long way off, yet the same documentation elements or guidelines have been around since the early 1990s.

The **challenge** for some providers is when they **switch** from the system they may be using in their office setting to what is used in the hospital or nursing home. Everyone seems to have their own system or forms to use. Again, the **same information** is required, but the format for documentation can be quite different. If a provider is not familiar with the basics, this can be a **daunting task**. Often, this is the **root of the problem** with medical records.

Dictation is costly. **Preprinted forms** with check boxes and such are great. Unfortunately, I see a number of these preprinted forms that never get filled out all the way. They often end up lacking the detail needed to document the full extent of the encounter. Not a good thing when it ends up as a legal case. **Hand written** notes are often difficult to read and also lack detail. **EHR/EMR** systems are excellent, but have a protracted learning curve and are sometimes intimidating to providers.

No matter what system you are using, you need to include the **correct information**. This is where the **BASICS** come in. The starting point is usually the collection of history. One of the most common areas of poor documentation that I encounter is the history. Remember, **anyone** can collect the history information, even the patient. There is nothing wrong with having a patient fill out a questionnaire while they wait to be seen. Medical office staff can assist patients with this task as well. The **history** should **include** the **reason** the patient is being seen or the "chief complaint." This is **expanded upon** by collecting information about the problem and its effect on the patient as well as timing. This is called the "**History of Present Illness**" or HPI.

The HPI as outlined in current guidelines consists of **8 elements**. These are, 1) location, 2) quality, 3) severity, 4) duration, 5) timing, 6) context, 7) modifying factors and 8) associated signs and symptoms. These are the elements that auditors look for. However, they are the **MINIMUM** elements. Other important information can and should be documented when it is



The Basics . . .

clinically appropriate.

A **review of systems** (ROS) is also part of the history collection. This allows a provider to determine if there are any **concerns or conditions** that may **influence** the present problem or if there are other **more pressing** symptoms that need attention.

There are **14 specific elements** of the ROS. They are, 1) constitutional, 2) eyes, 3) ears, nose, mouth and throat, 4) cardiovascular, 5) respiratory, 6) gastrointestinal, 7) genitourinary, 8) musculoskeletal, 9) integumentary, 10) neurologic, 11) psychiatric, 12) endocrine, 13) hematology and lymphatics, and then 14) allergy and immunology.

Good medical practice (and the **standard of care**) dictates that every patient encounter include documentation of the ROS to some extent. It can be problem pertinent or comprehensive, but it should be documented. Again, this can easily be accomplished by having the **patient** answer questions on the same form as the HPI. **Office staff** should be trained and ready to **assist** with some patients that inevitably **struggle** with these types of forms.

The **final part** of history collection centers around **three specific areas**, 1) the patient's past medical history, 2) family history and 3) social history (PMFSHx). There are **no specific or mandated elements** of documentation for each of these areas. However, some important considerations would be documentation of childhood illnesses, adult illnesses, pregnancy history, hospitalizations, surgeries, current drugs (prescription and over-the-counter) and allergies to drugs for a complete personal medical history. Family history would include major illnesses or diseases of parents, grandparents and siblings. Social history includes information about the patient's occupation, education, diet and exercise, habits and sexual practice.

I believe that requiring patients to review and update this history information consistently and at every encounter helps patients **take responsibility** for and be aware of their personal health information. It is also key to providing **excellent health care**.

Some **key points** to remember are that if you are seeing a patient often, you do not need to repeatedly collect all of the same information over and over again. It is appropriate to review it and **update** it on *every visit*. Update the HPI and then ask if any new medications have been added, if the patient has seen any new providers or specialists, if any family members been diagnosed with major health problems, and so forth. Again, don't hesitate to **take advantage** of the time the patient has to wait to be seen. A simple information sheet with **appropriately phrased questions** can be filled out at every visit. It will provide **invaluable information**.

It then becomes a **simple matter** to transfer any new information to the patient's chart. Paper charts often have a medical history sheet in the chart. This should be **current** and reflect the last time it was updated and by whom. Electronic charts have history sections too. It is amazing how often I see this part of the medical record filled out in detail during a first visit, but then **neglected** for long periods of time thereafter. Sometimes years. At the **very least**, a history sheet should be updated on an **annual basis**.

What is **required** is that when you do review and/or update the information, it be documented, even if there is no change in the information. A provider simply has to make a statement somewhere in the **encounter note** that the information was reviewed and updated or that no changes were needed. It is important to note that the provider needs to document their **own review** of the history section. This needs to be done in the encounter note. Otherwise, there is **no evidence** that the provider did review the information, even if it was updated.

Collection of history (HPI, ROS and PMFSHx) is part of the **standard of care**. Failure to follow this standard leaves one open to the risk of missing important information essential to the care of our patients.

Once the history is **documented and understood**, medical decision making becomes less of a challenge and is often directly influenced by the overall medical history of the patient. This ties in directly with the "**Nature of the Presenting Problem**" that we have discussed before. The remaining **challenge** is to perform and document a **medically appropriate** physical exam.

Since **evaluation and management coding** is directly linked to all of these elements (history, exam and medical decision making) the task is simplified by collecting all of the correct information, all of the time, in an efficient and timely manner. This task need not be cumbersome nor intrusive. **It is good medicine.**



If you are unsure of what constitutes history, exam and medical decision making (you are not alone), you should consider getting a **POCKET CODER** which outlines the specific elements of a patient encounter in an easy to understand matrix format. See information on the **PRODUCTS** page of this web site.

Productive Provider Newsletter

is published electronically by
Jim Meeks, P.A.-C. doing business as
M.P.E.C.S.
PO Box 899
Pleasant Grove, Utah 84062-0899
www.mpeccs.org

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