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Documentation Tips and Tricks: How to Avoid Common Mistakes

Every day we see coding mistakes that affect the accuracy of E/M coding levels. Some of them can be costly. So, in this issue of Coffee & Coding, we'll look more closely at some of these common errors—and help you avoid them.

Here are five areas where we most commonly see mistakes:

HISTORIANS

We see a lot of confusion around two aspects of this rule: (1) Who qualifies as a historian allowed to help convey the patient's needs? and (2) What is the proper way to document that an independent historian was involved?

Proper documentation identifies who the historian is and states explicitly that the information came directly from that person. Pediatric charts are where we most commonly see problems. In the case of a toddler, for example, it is not enough to note that a parent was present, even though the child is too young to communicate, and the obvious inference is that information came from the parent. The dictation must explicitly state that the patient's history was obtained from the parent/guardian. When in doubt, spell it out: "The parent states…" or "the guardian expressed concern that…" or "the parent noticed…"

The documentation must also include the historian's relationship to the patient (mother, father, grandparent, grandchild, guardian, social worker, police officer, group home counselor/assistant, etc.) and why the historian is needed. It's a common misconception that the historian can only be a family member; it can be anyone who is able to speak on behalf of the patient. But remember: If the patient can communicate their needs, then a historian is unnecessary. The dictation must explain why the patient cannot speak for herself (e.g., too young, memory loss, medical

condition that leaves them unable to communicate). Otherwise, the documentation is incomplete—and could be the difference between Level 3 and Level 2 in the Data portion of medical decision-making (MDM).

SENT TO ED/HOSPITAL ADMISSION

Most records will note if the patient was sent to the emergency room and/or admitted to the hospital. But that information by itself is not enough for the Risk portion of MDM. What's missing? You must also document a "warm handoff "or need for admission. If you called ahead to the ED or hospital, document the title of the person you spoke with and alerted to the patient's arrival or need for admission; this counts as a warm hand-off. If you call ahead and state that the patient is coming and needs to be admitted for emergency surgery, you must specifically note this, too. Correctly documenting the situation's urgency could be the difference between Level 3 and Level 5 in Risk.

OVER-THE-COUNTER

We see many charts documenting, with no specificity, that a patient received an over-the-counter medication. Some insurance companies will accept this and give you the Level 3 credit. Most will not and require the dictation to state which OTC medication was administered. If it is Tylenol, Mucinex, or Robitussin, then make sure it's listed. Some OTC medicines with higher dosages can become prescription-strength, such as Voltaren 4% or Motrin 800mg, and this could be the difference in the Risk category that escalates an encounter from a Level 3 to a Level 4.

RECORD REVIEW

To get credit for record review, the documentation must clearly state where the records are from. You cannot receive credit for previous visits/labs in your office that you or your colleagues ordered. Here's an example of documenting it correctly: "I reviewed the records from [XX Hospital] or [Physician Name and Type of Specialty]."

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TIME

Did you know that, if you are billing by time, all the time spent in a 24-hour period counts towards the end time? For example, let's say you spend 10 minutes reviewing a medical record received from an outside office. Then, after the patient leaves, you spend another 15 minutes on a call with a specialist/physician counseling for the treatment. And then later in the day, you spend another 15 minutes on a call with the patient to discuss test results and the prescribed treatment or medication. All these activities count toward the total time.

When should you bill by time instead of billing purely by E/M codes? While it may be simpler to bill by codes, there are times when that practice could cost you reimbursement revenues you legitimately earned. For example, for encounters involving patients with complex conditions that need more of the provider's time, it makes sense to bill by time if the visit was longer than 45-60 minutes. In those cases, apply an extra code 99417 for every 15 minutes over the base amount of time.

Billing by time has also changed for 2024. You can no longer bill by time ranges; instead, record the exact number of minutes involved in the encounter. If you spent 53 minutes with the patient, the dictation must state 53 minutes, not 45-60. Word to the wise: It pays to include a breakdown of this total time in the documentation, itemized by tasks such as reviewing records from an outside source, the patient visit, and follow-up after the patient leaves the office. Much better to be safe now than sorry later.

Got a question about E/M coding? We'd love to hear from you.
Submit your questions by emailing us at coders@calmwatersai.com!

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