CHAPTER 7 - MEDICAL DOCUMENTATION

A patient note has many different functions. First of all, it's a potential medico-legal document. From this perspective, the more detailed the note you write, the better it is because in the setting of a medico-legal case, it is close to impossible to remember anything in detail. A well-written, detailed note is the best defense you can ever have. It is strongly recommended that a neutral, professional tone be used when writing medical notes. You never know which of your notes will be reviewed by lawyers to find information to attack you and other people, including your colleagues. A wide differential diagnosis is always fine, but providers should refrain from unsupported speculation. It is important to document the words exactly as spoken by the caregivers rather than summarizing them in the note. If you see any red flags that suggest potential medico-legal issues, such as complex social situations or friction between providers and caregivers, it is a good idea to write a detailed, neutral note based on the available facts.

The second function of the note is that it is probably the best communication tool in the healthcare system. A well-written, short note is a much better communication tool than long conversations or long, obscure notes, as everyone can refer to it at any time, keeping every member of the team on the same page.

Billing is yet another function of a medical note. To obtain appropriate reimbursement, medical documentation should support the reported ICD and CPT codes. For example, if you bill level 5 in the office but only document a simple URI with no extensive time, labs, or high risk, then your claim will be denied.

Like code selection, medical documentation can also be based on MDM or total time. Code selection and documentation should align, which means if you base your code selection on MDM, then your documentation should also be MDM-based. If you select the code based on time, then the documentation should also be based on time.

1-DOCUMENTING MDM-BASED CODES

MDM-based documentation of an MDM-based code

There are only 2 things to document

1-Medically appropriate history and/or examination

2- Level of MDM

Please note that it is up to the physician to decide how much history and/or examination are documented. Please also note the wording in the CPT code "*history and/or examination*". It is up to the physician to document either history, examination or both. Just document what is medically necessary or appropriate for that encounter.

If you select a high level of MDM, you should document a patient or clinical situation that qualifies for that level. If you select a high-level code like 99215 and document low-level MDM, then your claim will be denied unless you select the 99215 based on time.

You are not mandated and do not need to document how much time is spent with the patient if you are basing the code selection on patient complexity or MDM level. You may ask: What if I base my code

selection on MDM and also include total time in the note? Is there any harm in doing both? Answer is: potentially yes. Time is irrelevant in MDM-based billing, and it's okay to document time as long as the time and the billed level correlate. But if there is a discrepancy between the MDM level you have chosen and the time you spent, an inexperienced auditor may erroneously downgrade your billing to a lower level.

As an example, let's say you saw a sick, complex patient on the floor and billed 99233 based on MDM/complexity. If you document in your note that you spend 25 minutes for patient care, the auditor may think "*25 minutes qualifies only for 99231!*" and may deny your 99233, because 99233 requires 50 minutes or more of care time. An auditor should not do this, but this may happen. You can have a similar situation in the office: billing 99215 and documenting 20 minutes of time, which is discordant with the 99215 time of 40 minutes. Because of this, one does not need to document time when code selection is based on MDM, especially if you are going to document a care time that is lower than the time associated with that code.

Please refer to Chapter 2 on MDM and practical tips on MDM selection. When a certain level of MDM is selected, you should document at least 2 elements high enough for that level. Consider using the terminology used in the MDM description to make it clear which MDM element level you are talking about. For example, in the problem category, if you use the term acute life-threatening illness or severe exacerbation, this makes the auditor think about high-level MDM or the highest level code.

Problem element

If you use the terms acute stable/uncomplicated illness/injury, that implies low MDM.

If you use the terms acute illness with systemic symptoms or complicated injury, it implies moderate MDM.

For any chronic disease which is not under good control (within the target goal), use the term chronic disease with exacerbation

Data element

Document if you obtained history or interval history from caregivers for independent historian. For example, *"history is obtained from mother ……."*

Document any external notes you reviewed. Example, *"neurologist's note reviewed, which recommended brain MRI and LP"*

Document reviewed labs. Example, *"I reviewed labs and imaging, CBC within normal, CRP and procalcitonin elevated, CMP within normal, lipase elevated."*

Independent interpretation of tests. Example, *"My independent interpretation of CXR: hyperinflation with perihilar infiltrates."*

Discussion management. Example, *"I discussed management with the gastroenterologist and started the patient on PPI and H2 blocker, and arranged endoscopy for tomorrow."*

Risk element

Prescription drug management aligns with moderate level MDM. Document in your note that you prescribed or renewed the medication for a specific condition. Just listing of medication and condition by the software is not acceptable. Example, "*Fluticasone inhaler renewed for well-controlled chronic asthma*"

Diagnosis or treatment significantly limited by social determinants of health aligns with moderate level MDM. Document in your note that the patient's social factors made it more difficult for you to evaluate and manage the patient's problems.

Drug therapy requiring intensive monitoring for toxicity aligns with high-level MDM. It may be reasonable to use the above wording exactly to let a potential auditor know that the patient has high-risk MDM. Example, *"patient needs weekly LFTs while on methimazole for monitoring for hepatotoxicity (Drug therapy requiring intensive monitoring for toxicity)."*

Decision regarding hospitalization or escalation of hospital-level care aligns with high-level MDM. Document your decision regarding hospitalization. Example: *"Given that the patient is hypoxemic and requires supplemental oxygen through HFNC, we will admit the patient."*

Use of **parenteral controlled substances** aligns with high-level MDM. Document the need and usage of the controlled substance. Example, "patient has not responded to acetaminophen and ibuprofen for pain and was started on IV morphine", "patient was given IV diazepam for muscle spasm"

The decision not to resuscitate or to de-escalate care because of poor prognosis aligns with high-level MDM. Document the discussion on DNR, DNI, or de-escalation of care.

Time-based documentation of an MDM-based code

You need to document 2 things.

1-Medically appropriate history and/or examination

2- Details and duration of total time spent for patient care

Prior to 2022/2023, you could only base code selection on time when the dominant part of the service was counseling and coordination of care. This is why old attestations universally stated "***more than 50% of my time spent in counseling and coordination of care***." Furthermore, only the time spent in the room, face-to-face with the patient, counted, not your 20 minutes of chart review before seeing the patient. It all changed in 2022/2023: now almost everything you do for patient care counts toward the total time, and you can base code selection on time at any time you like, regardless of counseling and coordination of care, so you no longer need the old attestation. You also don't need to be face-to-face with the patient for the time to count. You could be off the patient's floor or out of the office, and time still counts. Activities listed below count toward the total time.

1. Preparing to see the patient: **chart review, review of tests.**
2. Obtaining and/or reviewing separately obtained **history.**

3. Performing a medically appropriate **examination and/or evaluation.**
4. **Ordering** medications, tests, or procedures.
5. **Counseling** and educating the patient/family-caregiver.
6. **Referring and communicating** with other health care professionals.
7. **Coordination** of care.
8. **Documenting** clinical information in the electronic or other health record ~ writing notes.
9. Independently **interpreting results** and communicating results to the patient/family.

Do not count time spent on the following:

The performance of other services that are reported separately under another CPT code. For example, providing procedural sedation and billing 99233. Because procedural sedation is reported with another CPT code, the time spent on procedural sedation is not counted toward the total time of the E/M service code, such as 99233.

Teaching that is general and not limited to discussion that is required for the management of a specific patient.

You are not expected to document every little detail on how you spent the time, including every conversation, but document the main points about how that time is spent. Instead of documenting "management was discussed with endocrinologist" you can write "management was discussed with endocrinologist who recommended a repeat HBA1c, close glucose monitoring, and higher dose of long-acting insulin."

You can create an attestation, like this: *"I spent X minutes for this patient, including chart review, review of labs, imaging, orders, history, examination, management discussions with X, education/counseling on X, and medical documentation."* Or *"total time spent for patient care is X minutes, including ……"*

2-DOCUMENTING NON-MDM BASED CODES (NORMAL NEWBORN, DISCHARGE, WCC)

These include hospital discharge day care services, normal newborn services, and preventative care/WCC codes. There is no mandatory amount of time or data needed to be documented for these codes, other than documenting time for hospital discharge codes. You should document the time spent on the day of discharge, because less than 30 minutes means 99238 and more than 30 minutes means 99239. While documenting for non-MDM-based codes, include whatever information is appropriate for that encounter.

3-DOCUMENTING CRITICAL CARE CODES

Documentation of critical care codes is more complex because one must document both a critical illness/care, as defined by CPT, and a high-level MDM. Critical illness and care are defined by CPT as follows:

"A critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability *of imminent or life-threatening deterioration in the patient's condition."*

"Critical care involves high complexity medical decision making to assess, manipulate and support vital system function(s) to treat single or multiple vital organ system failure and/or to prevent further life-threatening deterioration of the patient's condition."

Based on these definitions, 4 points need to be documented in critical care notes. The 5th point (total time spent) applies only to time-based critical care notes, as these codes are based on time.

1- Acute, vital organ impairment

2- High probability of deterioration, either imminent or life-threatening

3- Assessment, manipulation, and support of vital system function

4- High complexity medical decision making

5- Total time spent (only for time-based critical care codes, 99291, 99292.)

The first requirement is documentation of critical illness, as defined by CPT. Based on the above definition, one should document impairment or failure of one vital organ and a high probability of deterioration. Otherwise, the patient may not be considered critically ill by the payers. If there is no acute vital organ impairment or failure, then there is no critical illness.

When documenting critical care, always document high-level MDM, because if patient management doesn't qualify for high-level MDM, it is not considered critical care from the CPT perspective. So, it is mandatory to document high-level MDM for critical care codes. Most critically ill patients should easily qualify for high-level MDM given the high-risk, high-acuity problems they frequently have, but it is important to document it. Providers should also consider documenting assessment, manipulation, and support of vital system functions as indicated, as these criteria are listed in the definition of critical care.

Apart from high-level MDM, time also needs to be documented when time-based or adult critical care codes are reported (99291, 99292). It is mandatory to document time spent, as these codes are time-based. When day-based or pediatric/neonatal critical care codes are reported, then documentation of time is optional. If documented, though the total time should not be less than 30 minutes, because per CPT, care that is less than 30 minutes is not considered critical care.

4-DOCUMENTING CONSULTATION CODES

It's recommended that when 2 providers report services for the same patient on the same day, they select different ICD codes to show that they are managing different parts of patient care. The claim of the second provider might be denied if the same ICD codes are used. For example, if a consultant lists the same ICD codes as the primary attending requesting the consult, the consultant's claim might be automatically denied, or it may trigger a review by the payer to ensure that services are not redundant

or duplicative. The request and the reason for consultation should be documented in the requester's or the consultant's note, or in a written order.

5-DOCUMENTING ICD CODES.

CPT codes are always reported with ICD codes. ICD codes tell the payer about the reason for service, while CPT codes tell the payer about the nature of the service. You should align your CPT codes with ICD codes. You should not just select the ICD code; you should also document it clearly in your note. You can select an ICD code for severe asthma exacerbation, but if you don't describe it in your note that the patient had severe asthma exacerbation or if you document a patient who has only mild asthma exacerbation, then your claim for the highest level code may be denied.

If you report high-level codes, list sicker-looking ICD codes, unless time-based billing is used. For example, if the sicket ICD code listed is URI, it may be difficult to justify code 99223, and the claim may be denied; however, it will likely be reimbursed if severe RAD exacerbation is used. If critical care codes are reported, the first listed ICD code should be a critical illness code.

For MDM-based codes, reported ICD codes should preferably reflect the patient's active problems being addressed, not inactive problems that are not addressed at that encounter. This is because chronic problems, if not contributing to medical decision-making, are not relevant in selecting the level of MDM. Although ICD for unaddressed chronic problems may be listed, they are not as important as the acute problems for MDM-based billing. If you are reporting higher-level codes, then list the appropriate sick ICD codes first, before unaddressed chronic problems.

6-DOCUMENTTAION REQUIREMENTS FOR TEACHING PHYSICIANS

Non-critical care notes

From the billing perspective, there are only 2 things that teaching physicians must document when attesting a resident or fellow note. First, documentation should make it clear that the teaching physician actually/physically saw the patient. *"I saw the patient"* or *"I saw and evaluated the patient"* or any similar sentence that makes it clear that you physically saw the patient is enough. Second, you should document that you participated in patient management (resident's note/plan). *"I agree with the resident note"* or any similar sentence is enough.

First comment: *"I saw the patient"* is needed because if you did not see the patient, you can't bill most CPT codes. Second comment *"I agree with the resident note"* is needed because without this comment, you can't own the resident note for documentation purposes. If the resident or fellow note has an appropriate level of documentation for the level of billing that you will report, then you do not need to write anything else. Your attestation on the resident note would be enough. All non-critical care note attestations can be a universal attestation with no patient-specific information, since you are only required to document that you saw the patient and agree with the resident note.

If the resident note doesn't contain sufficient documentation for the level you are targeting, you should either ask the resident to provide more detailed documentation or include the relevant documentation in your attestation.

Example of acceptable attestation. *"I saw and evaluated the patient. I reviewed the resident note and agree with the resident findings and plan of care"* or *"I saw the patient and agree with the resident note except that pain is still poorly controlled and we will add IV morphine prn."*

Unacceptable attestation examples: *"agree with above", "rounded, reviewed, agree", "discussed with resident"*. These are not acceptable because it is unclear whether the teaching physician saw the patient. *"Patient seen and evaluated"* is not acceptable because it is unclear whether the teaching physician agrees with the resident's note or contributed to the plan of care.

For MDM-based codes, when the teaching physician bases code selection on time, then the resident's note becomes less important from the billing perspective. This is because, regardless of the resident note, the teaching physician should still document the time spent on patient care and how it is spent. Although the resident note can be used to document care details, the teaching physician should still personally document the time spent.

Critical care notes

Critical care note attestations require 4 additional comments, in addition to the 2 above (I saw the patient and agree with the resident note). Because 3 of the 4 comments are patient-specific, critical care attestation can't be a universal attestation and should always include patient-specific information.

Additional documentation

1) Patient was critically ill.

2) What made the patient critically ill?

3) Treatment/management provided by the teaching physician.

4) Time teaching physician spent (only applies to time-based critical care codes).

Example of acceptable critical care attestation. *"Patient developed hypotension and hypoxia. I spent 45 minutes while the patient was in this condition, providing fluids, pressor drugs, and oxygen. I reviewed the resident's documentation, and I agree with the resident's assessment and plan of care."*

Example of unacceptable critical care attestation. *"I came and saw the patient and agree with the resident."*

Procedural notes

For minor surgical procedures (intubation, central line, LP, endoscopy), the teaching physician should document in the attestation that the teaching physician was present for the entire procedure.

Example of teaching physician attestation of LP*: "I supervised the LP and was present for the entire procedure."* This is enough documentation to own the resident procedure note and report the CPT code for LP under your name.

For a major surgical procedure, the teaching physician attestation should document that the teaching physician was present for key portion(s) of the procedure.