Documentation Guidelines for Physicians Interventional Pain Services

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343.8791
General Principles of Medical Record Documentation

- Legible entries including your “Signature”
- All entries must be signed and dated this includes electronic notes
- Order must be signed and dated includes electronic notes
- Documentation must be timely and complete
  - Reason for the encounter
  - A relevant history
  - Exam findings
  - Your plan of care
  - Reason for lab, x-ray, and/or consult requested
Documentation Guidelines

- A complete note should be handwritten in the chart, typed or dictated into Star Panel within 24 hours of a clinic visit.

- Admissions and H&Ps must be completed within 24 hours of admission.

- Operative reports and/or procedure notes must be completed immediately following the surgery or procedure.
Unacceptable Documentation

Stamps, dictation / EMR macros, decals and other forms of preprinted verbiage are not acceptable except when personal observations are added to the entry.
Components of the Global Surgical Package

- Preoperative visits after the decision is made to operate beginning the day before the surgery for major procedures (90 day global) and the day of surgery for minor procedures (0-10 global)
- Intra operative services that are normally a usual and necessary part of the surgical procedure
- Complications following surgery including all medical or surgical services required of the surgeon during the postoperative period of the surgery because of complications which do not require additional trips to the operating room.
Components of the Global Surgical Package

- Postoperative visits – follow-up visits during the post operative period of the surgery that are related to recovery from surgery
- Post surgical pain management by the surgeon
- Supplies
- Miscellaneous Services such as dressing changes, local incision care; removal of operative pack; removal of cutaneous sutures, staples, lines, wires, tubes, drains, casts and splints; insertion, irrigation and removal of urinary catheters, routine peripheral lines, nasogastric and rectal tubes, and changes and removal of tracheostomy tubes
Modifier 25

**Modifier -25** - (as defined by the American Medical Association Current Procedural Terminology: CPT 2007, Professional Edition) Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service. The modifier was created for situations when the physician needs to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. The E/M service may be prompted by the symptom or condition for which the other procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding modifier '25' to the appropriate level of E/M service. Modifier 25 is used to identify a significant, separately identifiable evaluation and management service performed on the same day as another procedure or service by the same provider.
Conscious Sedation

CPT codes 99143 to 99145 describe moderate sedation provided by the same physician performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient’s level of consciousness and physiological status. The physician can bill the conscious sedation codes 99143 to 99145 as long as the procedure with it is billed is not listed in Appendix G of CPT. CPT codes 99148 to 99150 describe moderate sedation provided by a physician other than the health care professional performing the diagnostic or therapeutic service that the sedation supports.

The CPT includes Appendix G, Summary of CPT Codes That Include Moderate (Conscious) Sedation. This appendix lists those procedures for which moderate (conscious) sedation is an inherent part of the procedure itself. CPT coding guidelines instruct practices not to report CPT codes 99143 to 99145 in conjunction with codes listed in Appendix G. The National Correct Coding Initiative has established edits that bundle CPT codes 99143 and 99144 into the procedures listed in Appendix G.
Procedure Attestation

008754319  TEST, DOMINIC P  (12/19/1954 - then 52YO M)

Attestation:
This attestation may be used in all procedures lasting longer than five minutes, except endoscopies. If you were present for the entire procedure, click here.

Type your attestation below, then click on 'Save attestation'.

I provided this service on: __________  time (optional): __________

I was present for the key components of the procedure.

Indexing comment (optional): __________

Your signature: __________

Gibson, Pamela J

Save attestation
Save attestation draft
Check spelling
Cancel
Spell Check
MyText
Procedure Attestation

008754319  TEST, DOMINIC P  (12/19/1954 - then 52YO M)

Attestation:
This attestation may only be used in procedures that are less than five minutes in duration, in all endoscopies, and in all procedures in which the attesting clinician was truly present for the entire procedure. If you were not present all the time, click here.

Type your attestation below, then click on 'Save attestation'.

I provided this service on:  time (optional):  

I was present for the entire procedure.

Indexing comment (optional):  

Your signature:  vusu1pxg  Gibson, Pemela J

Save attestation
Save attestation draft
Cancel
Spell Check
MyText
Components of an Evaluation and Management Service

1. History
   - HPI, ROS, PFSH

2. Exam
   - Body areas and organ systems

3. Level of Decision Making
   - Number of treatments options
   - Amount of data/complexity
   - Level of risk to the patient
Must Have ... Chief Complaint

A concise statement describing the symptom, problem, condition, diagnosis, physician recommended return, or other factor that is the reason for the encounter. Usually stated in the patient’s own words.
Evaluation and Management Service
History of Present (HPI)

- History of Present Illness - The first sign and/or symptom or from the previous encounter to the present
  - **Location** – where the symptom or problem is occurring
  - **Severity** – a rating or description of severity of the symptom or pain
  - **Timing** – when the symptom or pain occurs
  - **Quality** – the character of the sign or symptom
  - **Duration** – how long a pain or symptom lasts, has been present, or persisted
  - **Associated signs/symptoms** – any organ system or body area complaints associated with the chief complaint
  - **Context** – instances or items that can be associated with the chief complaint
  - **Modifying factors** – actions taken or things done to effect the symptom or pain, making it better or worse

Extended = 4+ documented
Evaluation and Management Service
Review of Systems

- Series of questions seeking to identify signs and/or symptoms, which the patient may be experiencing or has experienced

| Constitutional | Musculoskeletal |
| Eyes | Integumentary |
| ENMT | Neurological |
| Cardiovascular | Psychological |
| Respiratory | Endocrine |
| GI | Hematologic/Lymphatic |
| GU | Allergy/Immunology |

Complete = 10+ documented
Evaluation and Management Service
Past, Family and Social History (PFSH)

- **Past** - past illness, injuries, operations, treatments, current meds, allergies

- **Family** - medical events of pt’s family, hereditary disease

- **Social** - martial status, living arrangements, current employment, use of tobacco, alcohol, drugs, level of education, sexual history

Complete = 3 documented
Evaluation and Management Service

History Tips

- History Unobtainable or Patient unable to speak
  - Physician must document the reason why the patient is unable to speak for example “intubated, unable to obtain history”
  - Full credit is given for a complete history in this situation

- At least 10 organ systems must be reviewed for a complete ROS. Those systems with positive or pertinent negative responses must be individually documented. For the remaining systems, a notation indicating all other systems are negative is permissible
Evaluation and Management Service
Physical Exam

- Organ Systems

<table>
<thead>
<tr>
<th>Constitutional</th>
<th>Musculoskeletal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eyes</td>
<td>Skin</td>
</tr>
<tr>
<td>ENMT</td>
<td>Neurological</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>Psychological</td>
</tr>
<tr>
<td>Respiratory</td>
<td>GU</td>
</tr>
<tr>
<td>GI</td>
<td>Hem/Lymph/Immun</td>
</tr>
</tbody>
</table>

- Cannot combine body areas and organ systems for comprehensive exam. Eight or more of the 12 organ systems should be documented for a comprehensive exam.
Evaluation and Management Service
Physical Exam – Tips

- A notation of “abnormal” without elaboration is insufficient.

- A brief statement or notation indicating “negative” or “normal” is sufficient to document normal findings related to unaffected area(s) or asymptomatic organ system(s).
Evaluation and Management Service
Medical Decision Making (MDM)

- Four levels of MDM
  - Straightforward
  - Low complexity
  - Moderate complexity
  - High complexity
Evaluation and Management Service Medical Decision Making (MDM)

Elements

- Number of diagnoses or treatment options
- Amount and/or complexity of data to be reviewed
- Risk of complication and/or morbidity / mortality
Evaluation and Management Service
Medical Decision Making (MDM)

- **Number of Diagnosis / Treatment Options**
  - Self limited or minor
    - Stable, improved or worse
  - Established problem
    - Stable, improved or worsening
  - New problem to examiner
    - No additional work up planned
    - Additional work up planned
Evaluation and Management Service
Medical Decision Making (MDM)

1. Self limited or Minor; stable, improved or worse

American Medical Association
- A problem that runs a definitive and prescribed course, is transient in nature, and is not likely to permanently alter health status or has a good prognosis with management/compliance.
Evaluation and Management Service
Medical Decision Making (MDM)

2. Established problem; stable, improved, well controlled, resolving or resolved
   - The diagnosis and treatment has already been started

3. Established problem; worsening, inadequately controlled, or failing to change as expected
   - It must be clearly documented or implied (pain has increased, etc.)
Evaluation and Management Service  
Medical Decision Making (MDM)

Number of Diagnosis / Treatment Options Tips

- The initiation of, or changes in, treatment should be documented. Treatment includes patient instructions, nursing instruction, therapies and medications.

- If referrals are made, consultations requested or advice sought, the record should indicate to whom or where the referral or consultation is made or from whom the advise is requested.
Evaluation and Management Service Medical Decision Making (MDM)

- Amount and Complexity of Data
  - Review and/or order clinical lab tests
  - Review and/or order in the radiology section of CPT
  - Review and/or order in the medicine section of CPT
  - Discussion of test results with performing physician
  - Decision to obtain old records &/or history from someone other than patient
  - Review and summarization of old records & or obtaining history from someone other than the patient & or/ discussion of case with another health care provider
  - Independent visualization of image, tracing or specimen itself (not simple review of report).
Evaluation and Management Service
Medical Decision Making (MDM)

Review and/or order clinical lab tests

- Any documentation of the review of tests previously ordered
  - Test results documented in notes – WBC elevated
  - Documentation that provider reviewed results

- Documentation that indicates tests have been ordered
Evaluation and Management Service
Medical Decision Making (MDM)

Review and/or order in the radiology section of CPT

- Review of report “not actual film”
  - Review of x-ray report documented – chest x-ray unremarkable
  - X-ray ordered and documented

- Review and/or order in the medicine section of CPT
  - Review of report or ordered test documented
  - EKG, Stress Test
Evaluation and Management Service
Medical Decision Making (MDM)

Discussion of test results with performing physician

- Discussion of verbal communication documented
  Pathologist viewing specimen and discusses with ordering MD tests results.

- PCP discusses test results with specialist
Evaluation and Management Service
Medical Decision Making (MDM)

Decision to obtain old records &/or history from someone other than patient

- Documentation should support the reason and/or need to obtain old records or to obtain additional history from someone other than the patient
Evaluation and Management Service
Medical Decision Making (MDM)

Review and summarization of old records & or obtaining history from someone other than the patient & or/ discussion of case with another health care provider

- Summarize the review of old record/history and document how it pertains to the patient’s current problem
- Must be additional and relevant information
- Notation of “old records reviewed” or additional history obtained from family” is insufficient without elaboration
Evaluation and Management Service
Medical Decision Making (MDM)

Independent visualization of image, tracing or specimen itself (not simple review of report) previously or subsequently interpreted by another physician

- EKG Strip
## Evaluation and Management Service
### Medical Decision Making (MDM)

<table>
<thead>
<tr>
<th>RISK</th>
<th>Presenting Problem(s)</th>
<th>Diagnostic Procedures</th>
<th>Management Options</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Minimal</strong></td>
<td>- One self-limited or minor problem (e.g., cold, insect bite, laceration)</td>
<td>- Laboratory tests;</td>
<td>- Rest;</td>
</tr>
<tr>
<td></td>
<td>- Malaria</td>
<td>- Chest X-rays;</td>
<td>- Gargles;</td>
</tr>
<tr>
<td></td>
<td>- Cystitis</td>
<td>- Urinalysis;</td>
<td>- Elastic bandages;</td>
</tr>
<tr>
<td></td>
<td>- Ultrasound/echocardiogram</td>
<td>- Ultrasound/echocardiogram;</td>
<td>- Sterile dressings;</td>
</tr>
<tr>
<td></td>
<td>- KOH prep.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Low</strong></td>
<td>- Two or more self-limited or minor problems;</td>
<td>- Physiologic tests under stress (e.g., catheterization stress test);</td>
<td>- Minor surgery with identified risk factors;</td>
</tr>
<tr>
<td></td>
<td>- One stable chronic illness (e.g., well-controlled HTN, DM2, catat disorder)</td>
<td>- Diagnostic endoscopy with no identified risk factors;</td>
<td>- Physical therapy;</td>
</tr>
<tr>
<td></td>
<td>- Acute uncomplicated injury or illness (e.g., cystitis, allergic rhinitis, sprain)</td>
<td>- Deep needle or incisional biopsies;</td>
<td>- Occupational therapy;</td>
</tr>
<tr>
<td></td>
<td>- Allergic reaction or insect bite</td>
<td>- Cardiovascular imaging studies with contrast with no identified risk factors (e.g., arteriogram, cardiac catheterization);</td>
<td>- IV fluids without additives;</td>
</tr>
<tr>
<td></td>
<td>- Acute complicated injury (e.g., head injury with brief loss of consciousness)</td>
<td>- Obtain fluid from body cavity (e.g., LV/Thoracentesis);</td>
<td></td>
</tr>
<tr>
<td><strong>Moderate</strong></td>
<td>- One or more chronic illness with mild exacerbation, progression or side effects of treatment;</td>
<td>- Cardiac imaging, with contrast, with identified risk factors;</td>
<td>- Minor surgery with identified risk factors;</td>
</tr>
<tr>
<td></td>
<td>- Two or more stable chronic illnesses</td>
<td>- Cardiac catheterization, contrast, with identified risk factors;</td>
<td>- Elective major surgery (open, percutaneous or endoscopic);</td>
</tr>
<tr>
<td></td>
<td>- Undiagnosed new problem with uncertain prognosis (e.g., lump in breast)</td>
<td>- Diagnostic endoscopy with identified risk factors;</td>
<td>- Emergency major surgery (open, percutaneous or endoscopic);</td>
</tr>
<tr>
<td></td>
<td>- Acute illness with systemic symptoms (e.g., pyelonephritis, pleuritis, cellulitis)</td>
<td>- Deep needle or incisional biopsies;</td>
<td>- Parenteral controlled substances;</td>
</tr>
<tr>
<td></td>
<td>- Acute complicated injury (e.g., head injury with brief loss of consciousness)</td>
<td>- Cardiovascular imaging studies with contrast with no identified risk factors (e.g., arteriogram, cardiac catheterization);</td>
<td>- Drug therapy requiring intensive monitoring for toxicity;</td>
</tr>
<tr>
<td></td>
<td>- Allergic reaction or insect bite</td>
<td></td>
<td>- Decision not to resuscitate, or to de-escalate care because of poor prognosis;</td>
</tr>
<tr>
<td><strong>High</strong></td>
<td>- One or more chronic illness with severe exacerbation, progression or side effects of treatment;</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Acute or chronic illness or injury, which poses a threat to life or bodily function (e.g., multiple trauma, acute MI, PE, progressive severe rheumatoid arthritis);</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- An abrupt change in neurological status (e.g., TIA, sensory loss)</td>
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<td></td>
</tr>
</tbody>
</table>
Evaluation and Management Service
Medical Decision Making (MDM)

- Any co morbidities underlying diseases or other factors that increase the complexity of MDM by increasing the risk of complications, morbidity and/or mortality should be documented
- If a surgical or invasive diagnostic procedure is performed at the time of the visit, the specific procedure should be specifically documented
- An urgent referral or decision to perform a surgical or invasive diagnostic procedure should be documented
Evaluation and Management Service

Time

- The AMA guidelines state that when counseling and/or coordination of care dominates more than 50% the physician/patient and/or family encounter (face to face time) then time may be considered the key or controlling factor to qualify for a particular level of E/M services.
- The total amount of time spent with the patient must clearly be documented
- The record should describe the counseling and/or activity to coordinate care
  - “A total of 30 minutes was spent with the patient, more than half of this time was spent discussing treatment options and subsequent effects of ___”
New Patient Definition

“A patient that has not been seen by anyone in your group/division in the past three years”
Consultations

- Payment is made regardless of treatment unless a transfer of the patient’s complete care occurs
- Within a specialty, consultations maybe requested of a sub-specialist
Types of Consultations

Office / outpatient

Inpatient (only one per hospital admission)

Follow-up (subsequent daily visit code reported)
Consultations Requirements

- **REQUEST** – the requesting MD must request the opinion of the consulting MD
- **REVIEW** – the consulting MD must examine the patient condition
- **REPORT** – the consulting MD must report the findings of the examined patient to the requesting MD via letter or note in Star panel
Diagnosis Documentation

- Establishes medical necessity for the patient encounter
- List the condition to the highest degree of certainty for the encounter or visit, such as symptoms, signs, abnormal tests results or other reason for the visit
- It is acceptable when a confirmed diagnosis has not been established to describe symptoms and signs, as opposed to diagnoses
- Do not document “rule out”, “possible”, “suspected”, “likely”, or “questionable” diagnoses
**GC Attestation**

**008754319**  TEST, DOMINIC P  (12/19/1954 - then 52YO M)

Pediatric Infectious Disease Daily Progress Note  2007/08/17  13:33  By: Lambiase, Pamela S  Signed by: lampez

on 2007/08/17 13:34:14

Vanderbilt University Medical Center  Test, Dominic P
Pediatric Infectious Disease Initial Consult Note  MR# 008754319

Date of services: Friday, 08/17/2007 13:33
Pediatric Infectious Disease

Daily Progress Note

**IDENTIFYING INFORMATION:** 52 year old female

**INTERVAL HISTORY:**

**PHYSICAL EXAM:**


**GENERAL:** awake and alert, well appearing, well developed, well nourished
GC Attestation

008754319  TEST, DOMINIC P  (12/19/1954 - then 52YO M)

Attestation:
This attestation statement is only for attesting to notes that have been written by fellow and resident physicians. It is not to be used to attest to nurse practitioner (NP) or physician assistant's (PA) notes. Note that the attending physician must document personally collected information into at least one of the following fields, it is not sufficient to attest without adding to the language below.

Type your attestation below, then click on 'Save attestation'.

I provided this service on __________ time (optional): ________

ROS, PFSH and EPI were reviewed and confirmed with the patient.

I examined the patient and confirmed the examination performed by the physician below.

I have reviewed the chart, tests, and labs. I have discussed the differential Dx, work-up and treatment plan with the physician below, and approved the plan.
NP/PA Attestation

008754319   TEST, DOMINIC P   (12/19/1954 - then 52YO M)

Attestation:
This attestation is for the purpose of a physician attesting to a nurse practitioner’s (NP) or physician assistant’s (PA) history. The attending physician can only attest to the NP’s or PA’s history for a component of their own history, but still must document his/her own brief HPI, physical examination, diagnosis, and plan. See the "Amend/Reviewed" selection in the "Actions" yellow pull-down tab in the event that the physician is not billing based on the note, but only reviewing for quality purposes.

Type your attestation below, then click on 'Save attestation'.

I provided this service on: [ ] time (optional): [ ]

I have reviewed the below practitioner’s patient history. I have also taken the patient’s history myself, and I confirm that the below history is accurate.

Indexing comment (optional): 

Your signature: vusrpzx

Gibson, Pamela J
Questions ??