Problems Addressed During an E/M Encounter

Appropriate documentation prevents audits and clawbacks.

BY MICHAEL J. KING, DPM

Auditors are looking at the issue of problems addressed in the encounter in the E&M billing and coding world today with a much more jaded eye.[1] We, as treating practitioners documenting our visits, need to keep in mind that a problem is not considered to be addressed just because the patient has the condition. This may vary somewhat from how we have been viewing this or being educated on by some coders. It is critical to see the documentation specifically identify that we not only recognized the condition but how we managed that problem, OR how it impacted what we are doing. We must document just how that impact affects what we decide to do in our treatment plans, thus leading us to selecting the proper level of service provided.

Encounters in a Hospital Setting

Let's take some encounters in the hospital setting. It is often found that the treating practitioner wants to bill a level 3 subsequent visit 99233. This can become a problem as other notes often state what the other specialists are doing to manage the various diagnoses and do not show how the treating practitioner assessed, managed, or had to consider all the conditions/symptoms when making their personal decisions. Does it impact what you are doing in your treatment plan? If so, it must be documented. Why does a chronic condition you are not managing affect the way you treat this patient?

Encounters in an Office Setting

In the office setting let's consider the acute visits which seem to vary and lead to confusion to auditors. Let's say a patient presents for management of an acute infection. Just because the patient has chronic conditions does not automatically increase the level of complexity of the presenting problems if the note only lists the conditions. In this scenario, we would need to see documentation showing how the conditions impacted decisions made, or complicated the patient's status or treatment of the acute problem. How did that diabetes with neuropathy affect your approach to care? We inherently know why, but we have to explain it in a story for an auditor to understand why it affected the decisions we made.

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AMA has a definition it provides via CPT for how we look at "problems addressed":

▶*Problem addressed:*

A problem is addressed or managed when it is evaluated or treated at the encounter by the physician or other qualified health care professional reporting the service. This includes consideration of further testing or treatment that may not be elected by virtue of risk/benefit analysis or patient/parent/guardian/surrogate choice. Notation in the patient's medical record that another professional is managing the problem without additional assessment or care coordination documented does not qualify as being addressed or managed by the physician or other qualified health care professional reporting the service.

Referral without evaluation (by history, examination, or diagnostic study[ies]) or consideration of treatment does not qualify as being addressed or managed by the physician or other qualified health care professional reporting the service. For hospital inpatient and observation care services, the problem addressed is the problem status on the date of the encounter, which may be significantly different than on admission. It is the problem being managed or co-managed by the reporting physician or other qualified healthcare professional

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and may not be the cause of admission or continued stay.

What You Need to Document

It is important to note that the diagnoses being considered as having been addressed means that the note tells distinctly this: what the provider personally did to either monitor and/or treat each individual condition/symptom or manage their care due to that condition. We don't just get credit for the disease because it exists. You must document how decisions that you, as the provider, made during the encounter were impacted by the fact that the patent has the symptom/condition.

Use of Macros

The development and use of macros to build the "Assessment" has become more of a listing of problems instead of the status of the conditions—how it affected the way you treated them, and how that then ties into an active treatment plan. This has resulted in the final product of documentation, not always clearly identifying the specific diagnoses that were a part of the decision-making thought process. This is an area that we need to consider during our audit reviews to help prompt change through education with our providers.

Continue to follow coding information streams via the APMA, CPT, or similar sources as well as utilizing your Medicare MACs for updated coding information. Don't find out something by way of an audit or clawback of funds you have been paid for providing good care. **PM**

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Reference

[1] Problems Addressed During an Encounter—NAMAS

Dr. King is Medical Director of Upperline Healthcare, Inc. and Past President of the APMA.