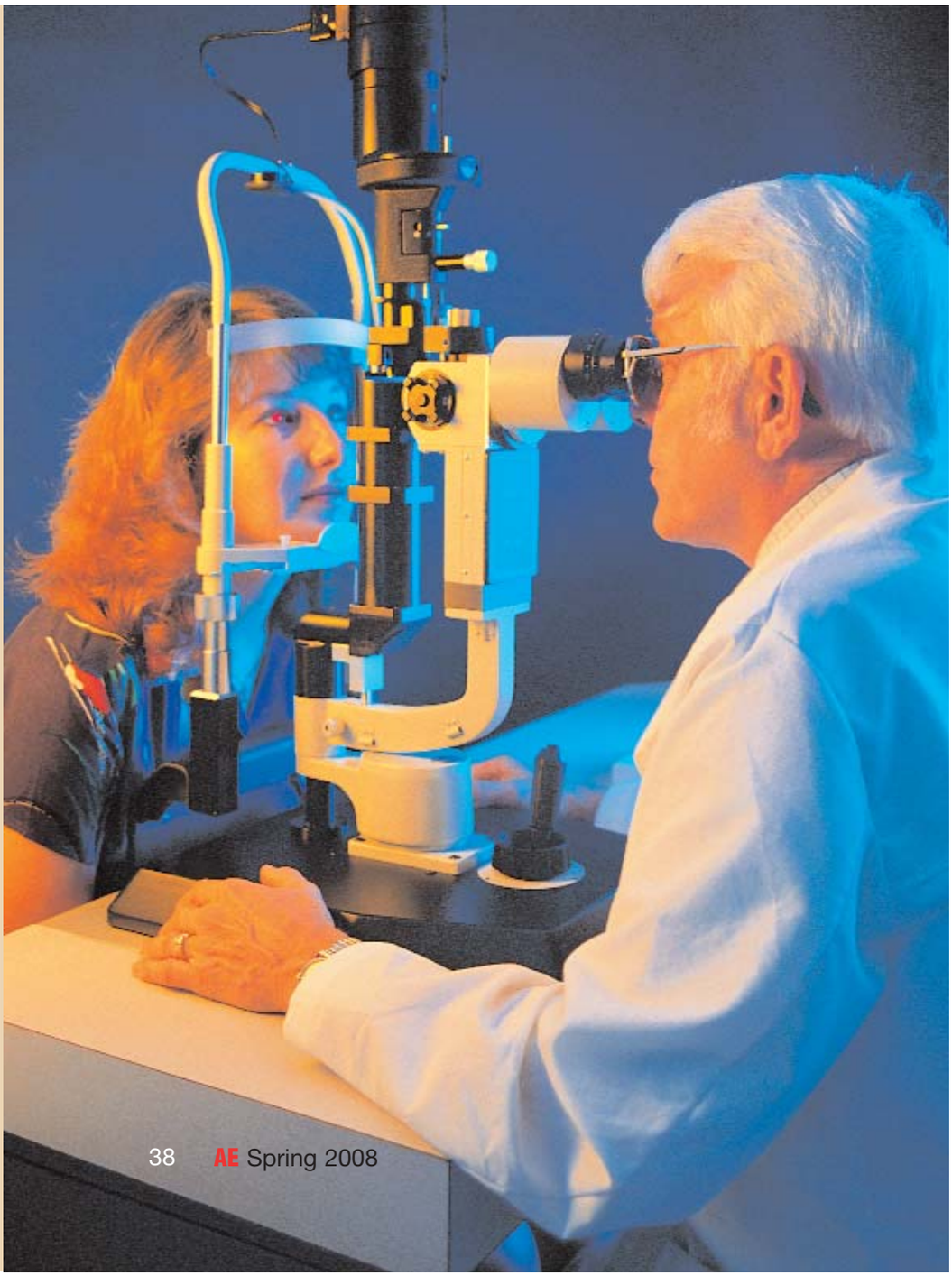
History Bears Repeating:

Avoiding Downcoding by Substantiating the Chief Complaint

Jane T. Shuman, COT, COE



The number one reason chart audits result in downcoding is that the history-taking component of the exam does not meet the standards for the level of care administered. This is particularly true for Evaluation and Management codes; high-level codes require at least four quantifiers substantiating the chief complaint.

Simply put, the chief complaint is why the patient is sitting in the chair. This can be one of three reasons:

- A new problem
- A return visit for an existing problem
- Routine care

Administrators are well aware that Medicare and many other carriers do not cover routine, or annual, vision exams.[1] These are often billed to a vision carve-out carrier such as VSP, Davis Vision, or Eye Med. The criterion for this type of exam is minimal, as it pertains to history taking.

Therefore, this article will focus on medical exams. Because ophthalmology has two sets of codes from which to choose, and because the E and M codes have more stringent criteria, the technician taking the history should assume every visit will result in an E and M code.

Verifying the Reason for the Office Visit

Because so much focus has been placed on speed, technicians are

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often trained to begin writing as soon as the patient begins to speak. Instead, the technician should verify the reason for the office visit with the patient first. If the calendar matches the time frame suggested for a return visit, the logical assumption would be "six-month follow-up for cataract OU." Otherwise, the technician must ask why the patient is here; logically, there is a new, or worsening, problem. The only way to begin is for the technician to review the last note in the record before calling in the patient from the waiting room.

Too often, the chief complaint is "Annual exam" or "Difficulty with current glasses," followed by a host of complaints. However, the first statement in the chart must be the reason for the exam. Therefore, Medicare will not cover the exam because annual exams and exams related to eyeglasses are considered non-covered services.

With frequent reminders, the technician can be trained to reword the above examples to "12-month return for a specific condition" or "Blurred vision at distance." The history of present illness (HPI), which will follow, will justify either complaint.

Specifying HPI

The HPI must be comprised of four quantifiers; there are eight from which to choose (see **Table 1**).

Asking about location and duration should be as automatic to the technician as brushing her teeth first thing every morning. Once she masters that, she only needs to ask two more pertinent questions. If this is a complex problem, however, good care mandates asking more than two. Negative responses are as valuable as positive ones; they indicate to an auditor that the questions were asked.

Learning which questions relate to specific conditions takes time and effort. Someone in every practice should be appointed to review these various associations with new clinical staff. Alternatively, encourage that staff shadow physicians to hear which questions are asked, and that charts be routed back to the technician for review after the encounter is complete. Too often, this loop is not closed, leaving the technician to repeat the same mistakes.

Table 1. Quantifying the history of present illness.

Quantifier	Example
Location	Where is the symptom or condition — OD, OS, OU, above eye, front of head, left upper lid, etc.?
Duration	How long has this been going on — two hours, three days, six months, a long time, etc.?
Timing	When does it occur — every morning, intermittently, chronic, at bedtime, etc.?
Context	What activity is associated with the symptom — driving, reading, blinking, darkness, etc.?
Quality	What terms are used to describe the symptom — red, blurred, sticky, etc.?
Severity	How bad is the symptom on a scale of 1 to10 — excruciating, mild, very painful, etc.?
Modifying factors	What makes it better or worse — sunglasses, OTC pain reliever, putting glasses on, stopping night driving, etc.?
Associated signs and symptoms	What else occurs when symptom is present — flashes with floaters, jaw pain with headache, headache with kaleidoscope phenomenon, etc.?

Questioning Based on Disease Rather Than Symptoms

There are times that the patient is returning, as directed, and not experiencing symptoms. In these instances, instruct the technician to perform a history based on the disease rather than the symptoms. Two common examples are diabetic eye exams and glaucoma. Questions to ask include

- the duration of the disease,
- the location (for example, any retinopathy in either eye?),
- what, if anything, the patient is doing for it, and
- any associated symptoms such as blurred vision when blood sugar is high or changes in peripheral vision.

Summing Up

History taking need not be lengthy nor time consuming. A few succinct phrases incorporating the appropriate quantifiers will inform the ophthalmologist better than run-on sentences that have no relationship to the actual problem. History taking is an art form that can be developed and refined with a little work, understanding, and a genuine curiosity about the problem. AE

1. For information specific to Medicare on obtaining and documenting the chief complaint, see Heather Freeland's article ("Medicare 101: Obtaining and Documenting the Chief Complaint") in the Payers column of *Administrative Eyecare*, Winter 2008.

Jane T. Shuman, COT, COE (617-314-6400; Jtshuman@eyetechs.com), is president of Eyetechs, Inc., Boston, Mass. Eyetechs is a nationally recognized authority on clinical flow, scheduling, and technician education.