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Charting with Purpose: Precision Strategies for Accurate Coding and Malpractice Defense

Urgent Message: A well-told story explaining your thought process during a patient encounter should contain all the elements required for accurate coding. Attorneys are less likely to question care when a logical and complete story is clearly documented.

Jeff Willis, MD

Citation: Willis J. Charting with Purpose: Precision Strategies for Accurate Coding and Malpractice Defense. *J Urgent Care Med.* 2024; 18(4) 13-16.

As a medical legal consultant, I have learned medical malpractice claims are an unfortunate reality of practicing medicine. The good news is only 1% of paid malpractice claims are related to care provided in urgent care centers.[1] The bad news is this number is expected to rise as we expand the number of urgent care facilities that provide resources for patients with limited primary care and emergency care access. As the number of urgent care centers increases, so might the complexity of conditions for which patients are seeking treatment. Currently, about 22% of urgent care paid malpractice claims are the result of significant injury or death.[1] The increasing complexity of patients being seen in UC will certainly result in higher numbers of claims and higher settlements or verdicts.

Despite well-trained providers, carefully designed triage systems, and exceptional staff and technology, bad outcomes are inevitable. When patients suffer harm, the most relevant record of events is our provider note, which will be scrutinized by the patient, attorneys, expert witnesses, and juries. Even with the potential for such scrutiny, we typically spend only a few minutes to complete each encounter note.[2]

In addition to the legal implications, the provider

note also establishes the evaluation and management (E/M) level for our billing departments. The E/M level guidelines are published by the American Medical Association (AMA) and referenced by public and private payers to determine the reimbursement for provider services based on the complexity of the patient visit. If we want to complete our documentation at work and not spend time finishing up charts at home, we must efficiently document the patient encounter and satisfy the AMA guidelines. To make our lives easier (and help our coders produce quick and accurate E/M levels for

Author affiliations: Jeff Willis, MD, On-Call MedLegal Consulting. The author has no relevant financial relationships with any ineligible companies.

billing), each of the electronic health record (EHR) vendors have systems optimized with checkboxes, macros, and complaint-specific templates.[3] Providers, however, must use great care when using these methods of charting to avoid "mis-clicks" that might require an uncomfortable explanation during deposition or trial.

AMA's revision of the E/M guidelines in 2021 gives providers the opportunity to avoid this potential mishap. The previous guideline versions relied on a complex point system in the history of present illness (HPI), review of systems (ROS), physical exam, and medical decision making (MDM). The updated urgent care E/M levels are based entirely on the MDM or time spent on the visit.

These guidelines were revised again in January 2023, further solidifying AMA's commitment to the Centers for Medicare and Medicaid Services' (CMS) Patients over Paperwork Initiative.[4] Since most urgent care visits are brief, time criteria are rarely used, and the MDM serves as the sole determinant of the E/M level. After spending years checking boxes and point-and-clicking our way to efficient charts, we now have the opportunity to change our approach. With the recent changes to the E/M coding guidelines, providers can now use our limited time to produce much higher quality charts.

While published for purposes of simplified and accurate coding and billing, the current AMA E/M guidelines have the added benefit of helping providers avoid successful malpractice claims. With the current guidelines almost entirely focused on medical decision making, providers now have more time available to focus on critical components of risk-mitigating documentation: describing the patient's clinical course and medical decision-making process.[5] To realize the full opportunity offered by the current guidelines, providers should reconsider their approach to each section of the encounter note.

History of Present Illness

E/M coding guidelines require a provider to document only a "medically appropriate" history for any level of service. There are no requirements for location, quality, severity, duration, or any of these specific—but frequently not applicable—details. If checkboxes are still present in our EHR, we can likely disregard them for the purposes of coding and billing.

Checkboxes work well to generate narrative paragraphs outlining the basic components of a patient's HPI, but they generally require "yes/no" answers to specific questions or symptoms. If a patient tells the provider they have a burning sensation in the skin just above their right breast, but the only checkbox available is "Chest Pain: Yes/No," an undisciplined "Yes" click might create a narrative that reads, "The patient has chest pain." A common strategy employed by plaintiff attorneys is the use of affirmative questions in depositions to force defendant providers to answer uncomfortable questions.[6] In this strategy, an attorney will get an affirmative answer to a simple question such as, "Do patients having a myocardial infarction frequently present with chest pain?" Once the defendant provider agrees with this seemingly obvious assertion, the attorney will point out the narrative in the HPI that describes the patient as having chest pain. This forces the provider to now explain why they did not rule out or even consider a myocardial infarction. Had the provider not used checkboxes in the HPI and simply described the symptoms as a burning sensation, they could have avoided this uncomfortable situation.

Instead of using checkboxes, we can now use our time to document the actual history of present illness. Our patients tell us their story, and we should document that story. Were they running down the hall because they were late to math class when they tripped and landed on their wrist? Were they driving to the grocery store to pick up a few things to make a birthday cake for their 12-year-old's birthday when they got dizzy and almost passed out?

Why do these details matter? While generally unimportant to diagnosis and treatment considerations, documenting specific details of the HPI helps us remember the patient years down the road when a malpractice case unexpectedly arises. It is like leaving a little reminder to ourselves to differentiate between the 200 wrist injuries we have seen in the last few years. This can be important when a provider needs to recall specifics that might not have been documented. For example, if a plaintiff asserts they were never told to follow-up with an orthopedic surgeon, but the provider's note helps them recall the case more clearly, they might remember the patient asking them if the surgeon's cast could be in their school colors. While not as concrete as documented follow-up instructions, these details have the potential to help a provider out of a sticky situation in a deposition.

Review of Systems

We rarely elicit a full ROS, but we have historically documented a complete ROS to satisfy our perceived coding requirements.[7] Since 2021, the AMA guidelines for E/M coding have dispensed with any requirement for documenting a ROS. However, a pertinent review of asso-

ciated systems should still be incorporated into the HPI. This approach is much more logical and helps tell a full story in one section of the chart rather than adding details in a completely separate area. Even better, it keeps the plaintiff attorneys from keying in on irrelevant documentation. It also prevents the provider from inadvertently checking the "negative" box in the system, which is clearly affected by the chief complaint. These discrepancies are easy targets to discredit us and our entire chart.

Past Medical History/Medication List

Just like ROS, there are no specific documentation requirements for past medical, surgical, or social histories. This data is typically auto-imported to our note and simply creates duplicate information from another user's prior documentation. This practice is so prevalent that a recent study found over 50% of documentation in one health system's records was actually duplicate content from a previous note.[8] It is not uncommon for this data to be outdated or entered inaccurately,[9] confusing the clinical picture and offering more opportunity for a plaintiff attorney to discredit us and our documentation.

For EHRs that permit end-user template modification, we should take the time to remove these automatic import functions from our notes. If this feature is not available, medical directors should work with their information technology department to modify the standard note templates. If there is relevant past history, include it in the HPI where it makes more sense and provides more proof that we considered the patient's presentation in the context of their chronic illnesses.

Physical Exam

The current AMA E/M guidelines require a "medically appropriate" physical examination. Similar to ROS, we rarely complete a full head-to-toe exam, but our documentation frequently suggests otherwise.[7] We do this based on our perceived necessity of a full exam to achieve an appropriate coding level. The current guidelines, however, allow us to focus on the appropriate body system and document only the exam we actually perform. This is critical for medical malpractice cases, as plaintiff attorneys can pick apart exam documentation, building their case around even a single errant or imprecise word.

For example, providers will often document a "normal neurologic exam" on patients who clearly did not require that portion of the exam. When pressed during a deposition on exactly what was done during the neurologic exam, providers could be stuck explaining why they did an unnecessary exam or why their documentation was fabricated. Instead of using valuable charting time to document a full exam, we should only document a detailed and focused exam without the use of checkboxes or macros. This supports your testimony in deposition or trial significantly more than a generic normal exam.

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Medical Decision Making

The documentation strategy discussed above is focused on minimizing unnecessary information and replacing it with a focused and medically necessary history and physical examination. In other words, less is more. MDM is just the opposite. This section of our chart should be robust and detailed. The E/M level for an urgent care visit is primarily determined by our MDM. Equally important, with our elimination of unnecessary information in the remainder of the chart, the MDM becomes the primary location for providers to tell the story of a patient encounter. This is where we'd be wise to spend 90% of our charting time.

The AMA coding guidelines recognize four types of MDM: straightforward; low; moderate; and high. The MDM serves to establish diagnoses, assess the patient's status, and/or select management options. The E/M level is defined by three elements of the MDM:

- The number and complexity of problem(s) that are addressed during the encounter
- The amount and/or complexity of data to be reviewed and analyzed (tests, orders, independent historians, discussion with external providers, interpretation of tests, etc.)
- The risk of complications and/or morbidity or mortality of patient management (decision to refer patients to an emergency department (ED), presence of relevant co-morbidities, prescription drug management, need for surgery, etc.)

These are well-defined categories with several sub-

groups and details contained within each. As providers, we work through most of these elements for each patient, but we do not need to remember them to produce a chart maximized for both coding and medical malpractice protection. If we just tell the story of our patient evaluation, the coders have all they need to accurately assign an E/M level.

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If we order and review labs or imaging, we simply document why we ordered them and how the results affected our diagnosis and treatment. If we obtain the history from a family member, we write down who they were and what they said. If we talk with the patient and use shared decision making to determine a course of treatment, we document our agreement or concern with the decision. If we consider referring the patient to the ED, but they decline, we document their specific objection for the refusal and our encouragement to seek further treatment if they change their mind. If we talk to a specialist on the phone to get guidance on timing of follow-up, we write it down. We simply need to document the story like we would tell it to a colleague at shift change. A well-told story will contain all the elements required for accurate coding mentioned above.

As a malpractice consultant, I work with attorneys to help them understand the medical aspects of their cases. Of all the notes I review for allegations of medical malpractice, those that clearly tell the provider's thought process in the MDM rarely get pursued beyond initial review. It is difficult for attorneys to question a provider's care when a logical and complete story of the patient encounter is clearly documented. Despite conventional wisdom in the medical field, plaintiff attorneys do not want to sue doctors unless they truly breached the standard of care. In fact, the majority of attorneys reject between 95-99% of cases they screen.[10] If they read our MDM and it sounds logical on the surface, they will typically pass on the case and move on to the next. There are other factors that go into their decision, but the quality of our documentation is a main determinant.

Conclusion

Medical billing consultants offer charting strategies to maximize reimbursement. Risk managers provide guidance on how to avoid successful malpractice suits. Until recently, the Venn diagram of these documentation recommendations barely overlapped. With the simplified AMA E/M coding guidelines, this is no longer the case. A purposeful approach to documentation allows us to provide the best care, get appropriately reimbursed, and protect ourselves from medical malpractice allegations should a bad outcome occur. When we document only what is relevant in the history and exam and spend our precious charting time explaining our thought process in the MDM, we can quickly and efficiently produce a note which reflects the important elements of the encounter and which will be robust enough for adequate coding and billing. ■

Manuscript submitted August 24, 2023; accepted November 21, 2023.

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