AMEDD Sustainment Training

AHLTA Documentation Impact on Coding

How to Systematically Use AHLTA and Built Templates to Earn Maximally Appropriate Credit (RVUs) for Every Encounter

Version 1.3

Prepared for the:

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1.0 Overview

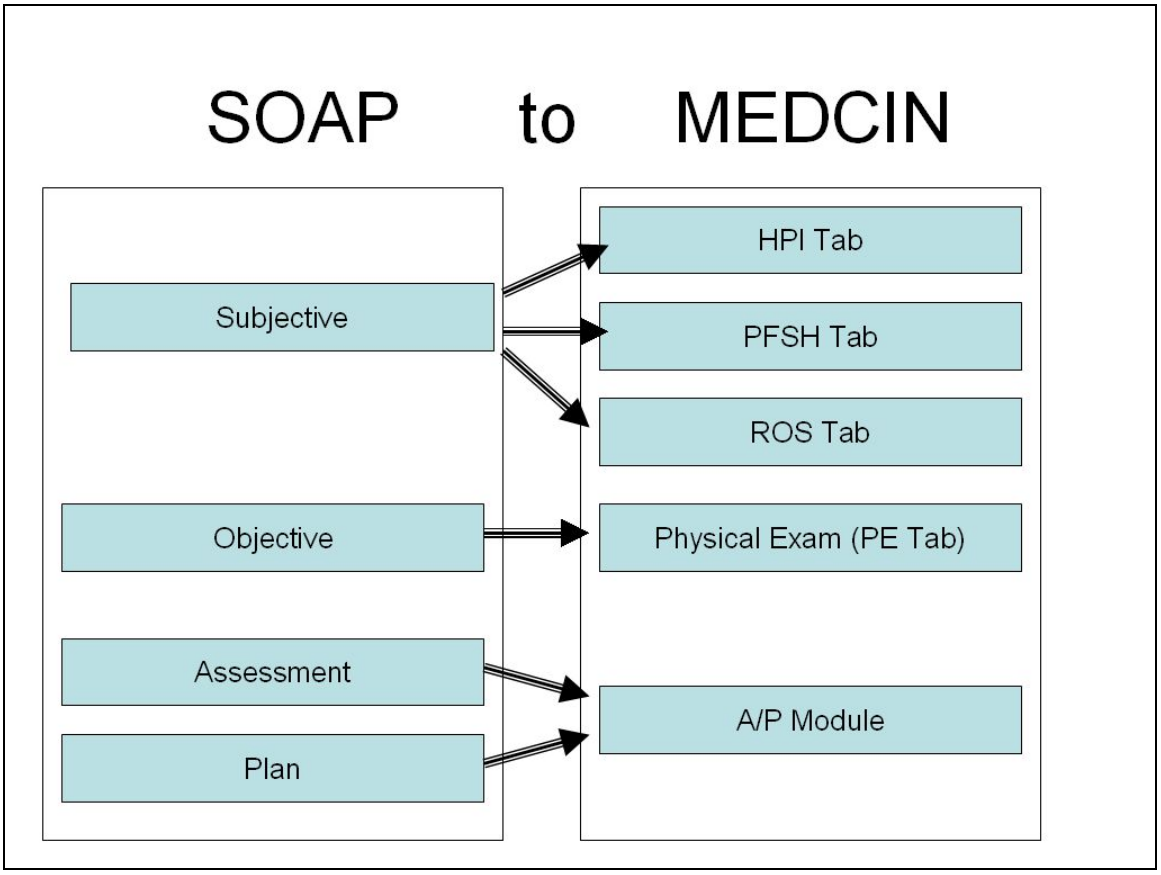
AHLTA offers the healthcare team many advantages from electronic completion of encounter notes. The biggest of these are real-time access by any provider anywhere in the world, comprehensive patient data, and an end to lost records, which is key for patient care and medical legal issues. While the potential benefits for both patients and doctors are substantial, today's reality is that heath care delivery is changing. This cultural change will require the provider to learn the capabilities of the system and how these capabilities can be used to improve healthcare delivery and manage the business of medicine.

With the simultaneous deployment of AHLTA and the change to the Next Generation of Tricare Contracts (T-NEX), military medicine finds itself at a crossroad. This crossroad is not substantially different from the financial issues and healthcare challenges facing civilian medicine. Military medicine is additionally impacted by the increased spending to support the war on terrorism, and the continued debate of how to fund military facilities or whether military medical facilities should be funded at all versus contracting healthcare to the free market. Any provider leaving the military to enter the civilian workforce quickly learns that clinical care and business are intimately related in what can best be called the clinical-business process. This process is based on coding and in the civilian world your job and the welfare of your family and patients depends on coding. The goal should never be more care, as more visits have never proven to yield better care. The use of AHLTA and the military healthcare system should focus on better care and outcome based on improving our clinical-business process.

While learning the changes necessary for the transition to a global electronic medical record system, the provider and healthcare team also need to learn about coding impact on the clinical-business system. Understanding the basics of coding will help earn you the credit (RVUs) you deserve now, and prepare you for future civilian practice. It will also help along with the larger changes brought by TNEX and AHLTA for the military health system to transform its manpower and clinical-business process. As always, the military healthcare system is leading the way in improving healthcare delivery and medical outcomes.

2.0 Relating SOAP Notes to MEDCIN Notes

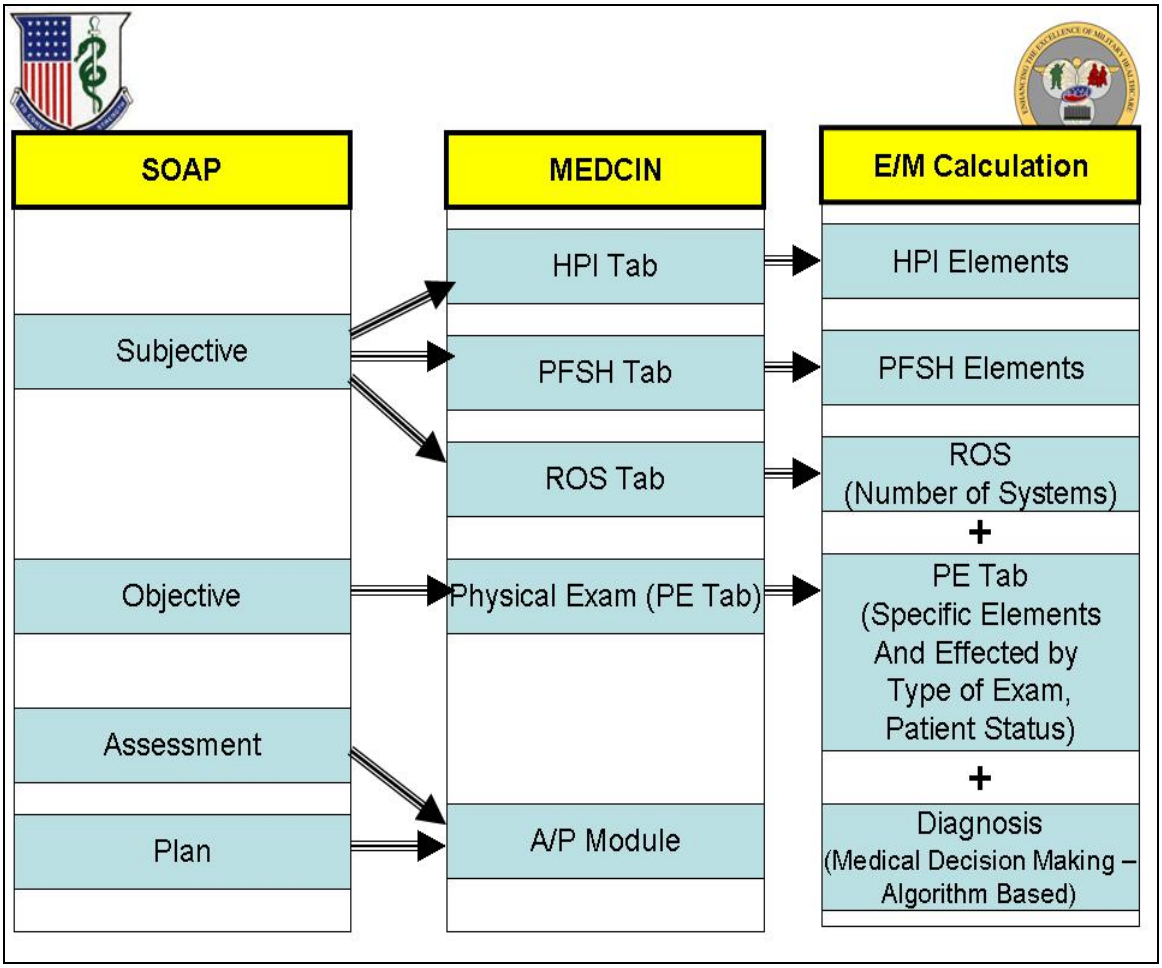
Most providers are familiar with the SOAP (Subjective, Objective, Assessment and Plan) note. At first glance, the MEDCIN template and AIM form appear completely disconnected from the pattern of note writing. The relationship between the SOAP note and the A/P module of AHLTA is reasonably clear. In fact, AHLTA allows the convenience of reusing a problem list and a personalized pick list to quickly enter a diagnosis and treatment. The comment/plan box under each diagnosis also permits an area for you to write your normal personal plan. The relationship of the MEDCIN categories of HPI (history of present illness), PMFH (past medical and family history), ROS (review of systems), and PE (physical exam) are less clear. In fact, they are the same. When writing a SOAP note, the provider is documenting elements of the present illness, pertinent positives and negatives, which are often a review of various systems, and collecting the necessary patient and family history. This information permits a focused objective evaluation to be done, which is recorded in MEDCIN as the PE.



As you see from the above graphic, the MEDCIN note is a typical SOAP note broken into its subcategories. For the Subjective portion, the coder or provider used to have to decide what information that was collected was part of each of these sections. The E&M code level assigned to a visit is based in large part on the work done. More specifically, the E&M level is based upon the specific work done in each category. This is why human coders do not always get the same results from coding a chart, as they would interpret what elements belonged to what section. It is also why AHLTA may give you a code that you or a coder thinks is wrong. The E&M level coding algorithm in AHLTA does not interpret. It assumes that you placed the data where you intended it to go. The impact of data location on coding will be reviewed in full later. The point to

remember now is that HPI requires a few entries to get maximum value. It is important to put some components in PFSH history. We actually do this all the time by reviewing medication history, allergies, and past patient or family history. Our review is not always documented. Review of systems simple counts the number of systems reviewed and NOT the amount of review of the system. Information entered under a system header, such as Pulmonary, will give credit for that system, as will no cough. Physical exam data requires very specific elements and certain number of elements. There is NO credit given for items listed under a system header.

The relation of SOAP to MEDCIN to Coding is depicted below.



Ignoring coding, the most important part of writing a note is its usability upon review. The question to ask once the relationship between SOAP and MEDCIN is understood is, “How can I make the note most useful to the clinical staff?” Finding information in notes is often difficult, not just because of legibility but because of format. Everyone does not write SOAP notes the same. A simple adoption of a plan to place ALL pertinent positives into HPI and pertinent negative into ROS

Note:	The MEDCIN terms in these are the same in the base MEDCIN template.

This action permits you to see what was ‘Wrong” with the patient in one location. It also provides an organ system breakdown of what was reviewed and found to be normal. This makes the note easier to read.

3.0 Template Building

For many providers, the greatest hurdle to AHLTA use is deciding on the best template to use. This decision involved finding or, often even more frustrating, building a template that allows good documentation of the clinical encounter, facilitates proper coding, and can be completed effectively. The frustration in this process is worsened by many myths about AHLTA documentation and coding. Without reliable, effective and thorough templates, the path of least resistance for most providers will be overuse of free-text boxes and minimization of structured organ systems examinations. Coding was never simple in CHCS. The providers were often divorced from the issue or simply documented a “standard” E&M code and a general diagnosis, such as “pain in the limb.” The integrated process of entering your diagnosis in the A/P module insures that your diagnosis matches the coding diagnosis. The system generated E&M code has been accurate, provided the system is used as intended.

3.1 Template Building Myths

I can’t use any free text. Reality: Appropriate free text is needed to provide clarity and specification to your exam. This usually involves a few words of typing after a MEDCIN term, particularly in ROS and PE. More typing may be needed in the HPI and in the Comment/Plan area under the diagnosis.

To get a higher code, more boxes have to be checked. Reality: The code level is influenced more by what boxes are checked then how many. The AHLTA coding calculator is a simple algorithm. Knowing the basics of that algorithm will help ease frustration and improve RVU earning.

I have to be a coder to understand what to code correctly. Reality: There are few simple items that the provider must be aware of to insure coding correctness. The reality is that coding is an art and professional coders often give different codes when reviewing the same encounter. The computer allows consistency, provided that the healthcare team gives it consistent data to calculate. Again, knowing the basics of that algorithm will help ease frustration and improve RVU earning.

This guide will help users understand the basics of the coding algorithm. The algorithm in AHLTA is the same as that used for civilian coding with few exceptions. This guide should be used in conjunction with the AMEDD AHLTA teaching material on Healthcare Team Documentation. The two will help show you how coding works and effective template building, and the process so that true efficiency and effectiveness to the encounter can occur. Although the provider is ultimately accountable for the quality of care, the documentation of care and the CODING of the care, this is not simply a provider issue. All these issues are the responsibility of the healthcare team.

4.0 Coding Components Impacting RVUs

The RVUs for an encounter are determined by the Evaluation and Management Code (E&M code) that is assigned and/or the Procedure (CPT code) assigned.

4.1 E&M Codes

Three components of the encounter note contribute to the E&M code. Grouped by functional areas, they are:

1) HPI/ROS/PFSH
2) Physical Exam
3) Medical Decision Making

AHLTA calculates the E&M code for the first two based upon the structured elements that it literally counts from the encounter note. AHLTA does not directly count items to determine the medical decision-making. Instead, it uses a weighted algorithm based upon the entered diagnosis to calculate an estimate of the complexity of medical decision-making. This is why a patient with chostochondritis may end up with a lower E&M code than expected, as initially you were considering angina as a diagnosis. These elements that are counted by AHLTA are found at the bottom of the "Disposition" page, immediately above the final code awarded. Remember, Medical Decision Making is not calculated. The Elements are:

Directly Calculated	Based Upon Entered Diagnosis
HPI	
ROS	Dx/Mgmt Options
PFSH	Complexity of Data
Overall History	Problem Risk
Exam	

In order to have AHLTA accurately code, you need to understand how these items contribute to the code computation. For the most part, AHLTA counts boxes within categories and organ systems. By understanding what boxes count and don't count, as well as the appropriate number of boxes that need to be checked in each category, you can determine the E&M coding outcome.

To receive a 99214, the following minimum combination of element scores is required:

	Diagnosis Example	
	UTI	**COPD**

	Diagnosis Example	
	UTI	**COPD**
HPI	2	2
ROS	2	2
PFSH	1	1
Exam	3	2
Dx/Mgmt	1	3
Complexity	1	3
Risk	1	2

Interpretation:

- For a new patient, all three larger areas are used for the calculation, but for an established patient, only two of the larger areas are used to calculate the E&M code.
- Attachment 1 shows a list of specific items that a human coder or the AHLTA coding calculator is looking for.
- The coding calculator DOES NOT give credit under Physical Exam for a “Normal System” (i.e. Respiratory System Normal), although it does under ROS. Additionally, only certain items in greater detail yield higher E&M calculations.

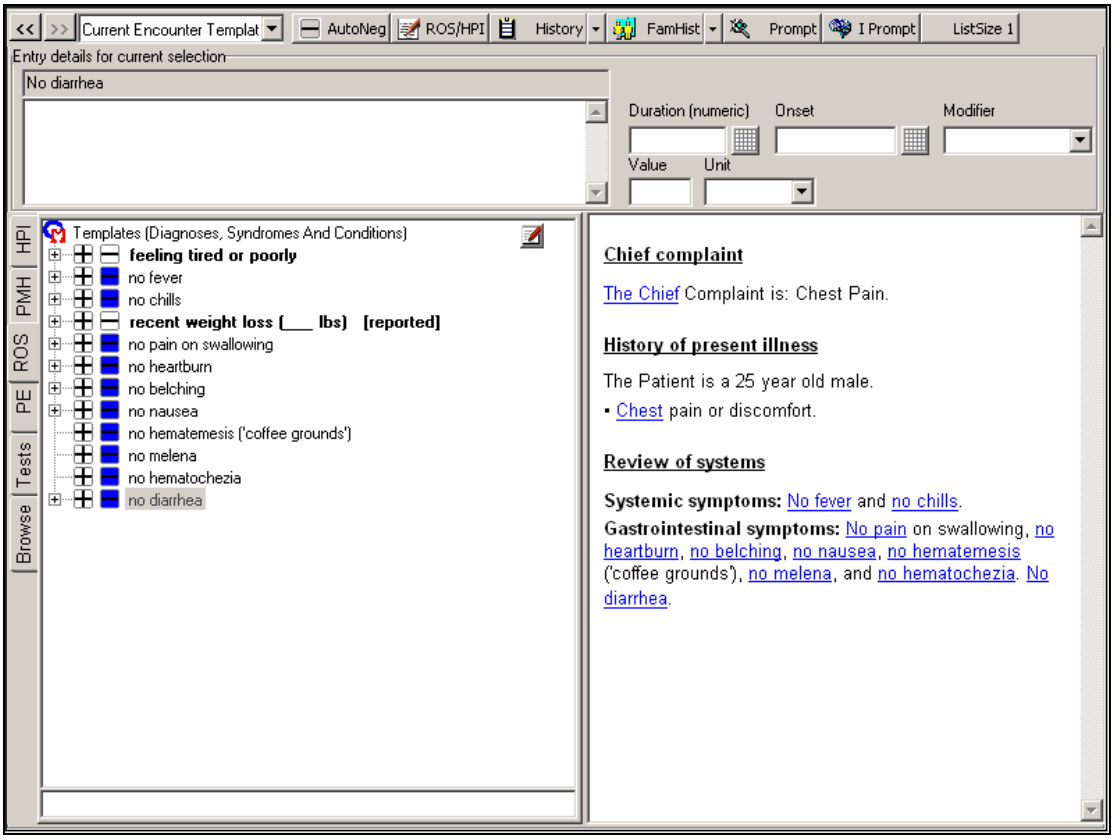
4.1.1 HPI, ROS & PFSH

You cannot get an accurate code without addressing these important elements. Here is the minimum number of blocks required to satisfy a 99214 requirements:

HPI	4	e.g., fever, chills, nausea, vomiting. This is not organ system specific.
ROS	2	This is organ system specific. Nausea and vomiting would be credited for only 1 ROS, but nausea and headache would count as 2.
PFSH	1	“No change” is acceptable.

Common Error

- All information in HPI and not ROS. Face it, providers write SOAP notes not HPI/ROS/PFSH/PE notes. Coders have interpreted where we intended the elements to go. AHTLA is a computer, it does not interpret your actions.
    - Option: Consider putting all pertinent positives in HPI. This also will make the note easier to read.

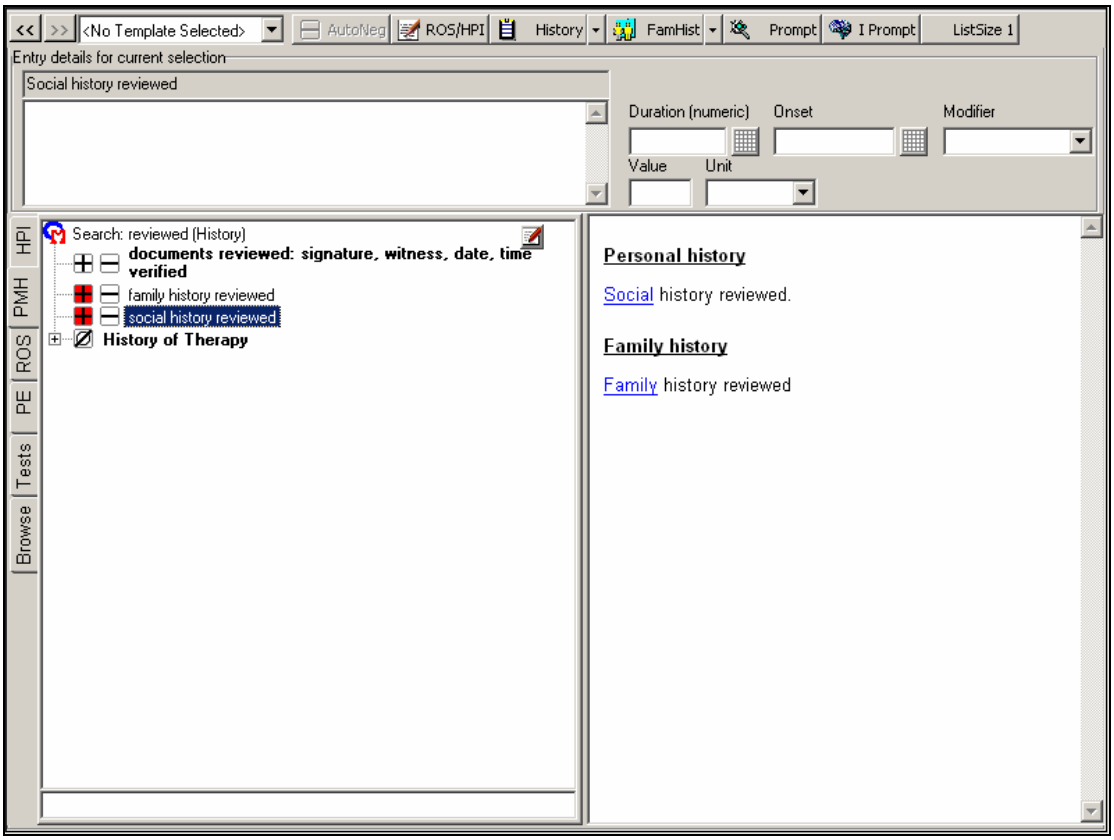


Note taking credit for reviewing a system.

- Option: Remember that pertinent negative count. If you asked about a system quickly check the system box and type what you specifically asked. The number of boxes does not impact this.

Note documenting any PFSH.

- Option: AutoCite is used in AHLTA to bring in past history on the patient and their family. The provider is medically legally responsible for this information. Take credit for this by documenting “No change” or “Reviewed.”



4.1.2 Physical Exam

Of the following 23 organ systems, 11 must be addressed to reliably earn a 99214. The list below indicates the number of boxes that must be checked to get credit for that particular organ system.

Number of Boxes Required to Obtain Organ System Credit

Vital Signs	1	Back	1
General Appearance	3	Abdomen	3
Head	0	Urinary	0
Eyes - @	1 or 3	Genital	1
Ears	3	Perineum	1
Nose	1	Rectal	1
Pharynx	2	Skin	2

Neck	1	Nails	1
Lymph Nodes	2	Musculoskeletal	0
Breast	1	Neurological - #	1 or 3
Lungs	3	Psychological	1
CV - *	2 or 4		

@any finding *other than* EOMI and PERRLA; 3 checked elements count as two organ systems

*4 checked elements count as two organ systems

#3 checked elements count as two organ systems

Common Errors

- Checking Normal or Abnormal after any of the organ system boxes above and adding free test in the comment box.
    a. Option: Do not build templates with the Organ system boxes on them. The boxes DO NOT give credit and the AutoNeg will stop on that box.
    b. Option: Create a personal default template that consists of items that you normal exam and give the possibility of a 99214 exam. Enter the positive findings and AutoNeg the rest of the exam if you did your normal complete exam.

4.1.3 Diagnosis

Diagnosis is a very important aspect of the AHLTA code. The Medical Decision Making Complexity is currently based upon the diagnosis. The AHLTA coding calculator cannot be changed by changing any of the elements on the disposition screen. This is being changed in a future built.

Presently do not waste a lot of thought here. Give the accurate diagnosis and include all diagnoses that you address.

Common Errors

- Listing only one diagnosis instead of all discussed.
    - Option: The easiest way to include all diagnosis is to first use the patient problem list and double click items discussed with the patient. Often multiple diagnosis are reviewed even when a patient came in for a single problem. Did you address the HTN, diabetes, obesity, smoking, or other? Order the diagnosis by the 1) reason for visit and 2) complexity.

4.1.4 Template or AIM Form Selection

A search of S/O template management for any common complaint or by specialty will easily return hundreds of hits. Most are not helpful clinically. The ones that are clinically useful often do not help with coding or JCAHO or military requirements such as “deployment related”. The best solution is to do one of the following:

- Find and use an AIM form designed for your specialty using it without or without a default encounter template.

Find and modify a disease specific template that is clinically useful (call a friend already using AHLTA) and check it against coding information provided here.

Take the time to build your own default encounter template. (See Healthcare team documentation)

Common Errors

- Providers try to do all the documentation
    - Option: Much of the HPI/POS/PFSH can be updated and documented by the healthcare team. The provider accepts accountability of all information when they sign the chart. Team documentation speed the completion of the encounter and insures getting credit for E&M and CPT coding.

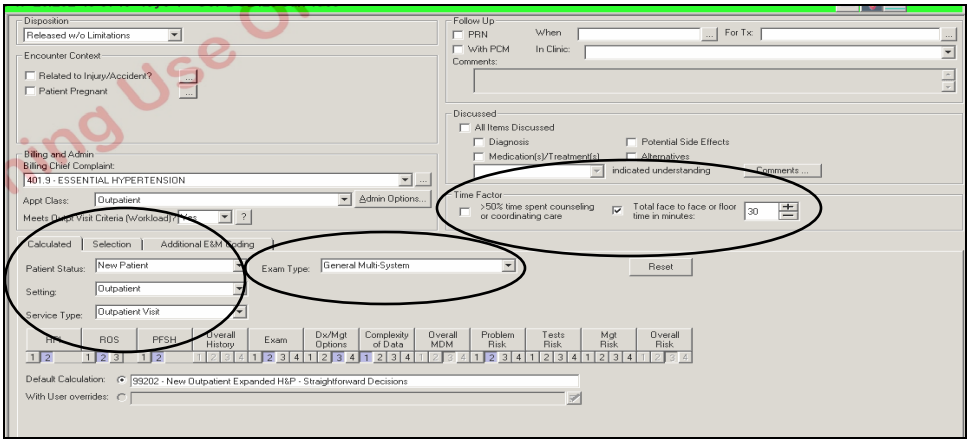
Using the MEDCIN term “Chief Complaint”

- Option: In AHLTA chief complaint is captured in multiple areas and the JCAHO does not state that encounter note has to say CHIEF Compliant. It states that the chief complaint of the patient has to be documented. This is done under HPI. The MEDCIN term Chief Complaint gives NO coding credit. DON’T USE IT!

4.1.5 Patient Status, Service Type, and Exam Type impact on Coding

In order to appropriately code the provider must insure that a few details are accurately given to AHLTA so that the appropriate set of calculation will be used.

Disposition Module Input:



Contributing Factors

Patient Status:

- **New Patient:** This is defined as no previous visits in the clinic with any provider in the last three (3) years. More RVUs are given for new patients.

Established Patient: Patient has been seen in the clinic within the last three years.

Common Errors

- AHLTA defaults to an established patient.
    - If the patient is a new patient by the three year rules, the patient status must be manually changed by the provider or a member of the healthcare team.

4.1.6 Service Type

The most common service types that will be used are outpatient visit, consult visit, preventive medical evaluation and management, and other.

- **Outpatient visit:** Used for most outpatient visits and for any follow-up visits after an initial visit for a consult if the same problem is addressed.

Consult visit: Used for the initial consult visit in a clinic for a specific problem. A second consult visit to the orthopedic clinic for a different joint would also be a consult visit. The consult visit should be linked to a consult appointment in CHCS.

Prev Med Eval/Mgt: Used for physicals, well woman exam, and newborn exams. These visits usually require a Vcode to be used as the initial diagnosis and are worth more RVU then a typical outpatient visit.

Other: The other unlisted E&M category is a military place holder used for visits by PT/OT, optometry, and visits signed by nursing staff. These visits receive RVUs based upon the procedure done (CPT code).

Common Errors

- AHLTA default is Outpatient Visit.
    a. Option: Check to insure that consult visit and prev Med Eval/Mgt appointment are used appropriately. They are worth more credit.
    b. Option: If your specialty is required to use the other (99499 E&M) make sure that this code is used and include the CPTs for all procedures that you do. (See your coder and set those you use most in your clinic favorites and your default clinic.)

4.1.7 Exam Type

The exam type also changes the number of items needed to achieve various E&M codes. (See attachment 1). AHTLA defaults to the General Multisystem exam. This will usually give the highest code but you can change the exam type to the other types to see if it makes a difference. Usually your template will need to be set up to maximize organ specific Exam types.

These include cardiovascular, EENT, eyes, genitourinary, hematologic, musculoskeletal, neurologic, psychiatric, respiratory, and skin.

4.1.8 Effective Documentation Philosophy

See Healthcare Team Documentation and Use of Default Encounter Template.

4.2 CPT Coding

The other aspects of coding that provides RVU value are the procedures that are done. Every procedure has some weighted RVU value. The healthcare team should document all procedures done in the clinic and associated them with the diagnosis. The common procedures done in the clinic should be listed in the clinic favorites for easy documentation. Additionally every provider should have their "Default Encounter Template" which will include not only the common procedures but common diagnosis and orders that the provider uses.

Common Errors

- Failure to document that a procedure was done.
    - Option: Make this a healthcare team responsibility. Who ever does the EKG or PFT adds the CPT code. The provider can associate it with the correct diagnosis.

Failure to list all aspects of the CPT. This is beyond the general discussion of this paper but often the procedure such as an immunization also has an administrative code, or education items have associated RVUs values.

- Option: See your local coder for a clinic specific assessment of what adds additional value not just extra work.

Summary

AHLTA provides an effective coding tool but requires appropriate clinical documentation and specific information to code appropriately. The provider (and healthcare team) does not need to remember multiple coding rules. Insuring that the basic are done and that coding is considered while building a single default encounter template will help to insure appropriate credit for the work that is done. Local codes can provide audits to help insure that changes to insure better coding are done in a clinic and provider specific manner as part of continuous process improvement.

E&M CODE	DESCRIPTION	RVU
99201	New Patient Focused Problem	0.45
99202	New Patient Expanded Problem	0.88
99203	New Patient Detailed Problem	1.34
99204	New Patient Comprehensive Problem	2.00

E&M CODE	DESCRIPTION	RVU
99205	New Patient Comprehensive – High Problem	2.67
99211	Established Patient Focused Problem	0.17
99212	Established Patient Expanded Problem	0.45
99213	Established Patient Detailed Problem	0.67
99214	Established Patient Comprehensive Problem	1.11
99215	New Patient Comprehensive – High Problem	1.17
99241	Consultation Patient Focused Problem	0.64
99242	Consultation Patient Expanded Problem	1.29
99243	Consultation Patient Detailed Problem	1.72
99244	Consultation Patient Comprehensive Problem	2.58
99245	Consultation Patient Comprehensive – High Problem	3.42

RVU's for E&M Services

RVU Math

- AMEDD Primary Care Provider RVU Goal - 15.3 RVU per day
- To achieve this a provider has to accomplish one of the following:
  - 99212 34 Patients per day meets criteria
  - 99213 23 Patients per day meets criteria
  - 99213 12 + 99214 6 meets criteria

Procedures

- Correct Documentation is Essential
- Procedure RVU's are added to the RVU's for E&M Codes

Description	CPT Code	Relative Value Unit
Dr. Supervised Injection - IM	90782	0.17
Dr. Supervised Infusion – Initial Hour	90780	0.17
Dr. Supervised Infusion – Additional Hour	90781	0.17
Rapid Strep Test	87880	2.00
EKG-Tracing only	93005	0.17
Pulse Oximetry	94760	0.04
Cerumen Removal	69210	0.61

Examples of Procedure RVU's

Examples of Properly Coded Visits

Well Women Examination

- E&M Code Prev Med Visit 99395 1.36 RVU's
- Screening Pap Smear HPCPS Q0091 0.37 RVU's
- TOTAL ENCOUNTER RVU's 1.73 RVU's

Impaired Hearing Visit

- E&M Code 99213 0.67 RVU's
- Cerumen Removal 69210 0.61 RVU's
- TOTAL ENCOUNTER RVU's 1.28 RVU's

Final Comments – Efficiency and Coding

1. The total number of MEDCIN terms does not drive the E/M calculator as much as how and where the terms are used.
2. A few words of ***free text*** (typing) after a MEDCIN term can add clarification and specification without negatively impacting coding.
3. The use of a personal DEFAULT TEMPLATE can automatically present you with
    a. The specific diagnosis codes you most commonly use

b. The specific procedure codes you most commonly use

c. A template of the MEDCIN terms that you prefer. This is especially helpful for documenting your ROS and PE.

4. If you have coding concerns ask your local coder for assistance.

5. You can check your personal or clinic E/M use for week using the report tool in AHLTA.