Charge Assist Documentation Guidelines for Providers

Overview

This document is intended to assist providers with recommendations and rationale to optimize the results of Charge Assist. The focus is entering sufficient detail into the Assessment & Plan where the tool is looking for medical decision making (MDM) criteria from the E&M guidelines.

General

Recommendation	Rationale
Document Chief Complaint/Reason for Visit **Examples:** Sore throat, follow-up for diabetes and HTN	The visit will not qualify for E&M billing code without Chief Complaint.
Use periods at the end of statements/sentences so the engine knows where to parse information to calculate the level of service accurately.	The engine will not accurately read/count the information if punctuation, spelling, and headers are not used correctly.
Use proper spelling.	
Use the headers appropriately during the workflow and note creation. **Examples:** • DO NOT enter diagnostic results in the HPI • DO NOT enter historical information not about the presenting problem/illness in the HPI	
Use the problems/problems list section on the Ambulatory workflow to enter the diagnoses for this visit. Only mark them as this visit if addressed today.	These numbered diagnoses will be coded by Charge Assist for your claim.
When billing based on time, use the appropriate time statement auto text to ensure the required information is included: *"I spent XX minutes face-to-face with the patient, and XX minutes in non-face-to-face activities related to the visit today. Total visit time is XX."* Clarify when a separately billed procedure/test is carved out from the total time.	Payers want to see how time was spent to determine if a higher level is supported. **Hint:** If making statements like, "I had a long discussion with the patient," time-based coding may support a higher level of service than medical decision making. The most advantageous of the two can be used for billing.
Include a header when documenting an addendum. **Example:** Assessment/Plan; list the additional information underneath the header.	Charge Assist will not know where to parse the additional information without the header.

DME Order Entry

Area of MDM	Recognized Words/Phrases		
Complexity of Problem Addressed	Acute Chronic Controlled Exacerbation Improving Likely	Not improving Onset Possible Probable Severe Severe exacerbation	Stable Resolved Uncertain Uncontrolled Worsening
Data Reviewed/Analyzed	Discussed with Dr. X from other specified specialty “I reviewed images” + specific findings Ordered Reviewed Dr. X/other source states		
Risk of Management Decisions	Continue Start/stop Adjust Recommend	Discussed Will proceed Patient agrees to Told patient to go to the ER	

Assessment & Plan (Medical Decision Making)

The visit is scored solely based on MDM, therefore, Assessment & Plan details are very important. Charge Assist will look for key information to level your service.

Recommendation:	Rationale:
Code all documented conditions that were addressed at today’s visit.	Charge Assist considers only your numbered diagnoses to level your medical decision making. No other numbered lists should be present in the note to prevent coding errors.
Managing prescriptions: Include the drug name for credit for moderate risk.	There is a difference in risk between OTC and prescription drugs. The drug name is needed to assign the correct level.
Enter the presenting symptoms as the diagnoses for the visit if a final diagnosis has not yet been reached. Include the differential diagnosis in the narrative comments.	The tool will not evaluate a note without a diagnosis/symptom. It is not appropriate to code probable/rule-out diagnoses (office/outpatient coding rules).