Office of Billing Compliance
Coding, Billing &
Documentation
2016

Department of Medicine
Division of Nephrology
Why Are We Here?

• To **EDUCATE** and **PROTECT** our providers and organization

• To provide your department/practice with every tool you need to maximize compliance and get paid what you deserve

• To update you on the latest CMS/OIG activities related to your specialty

• To give you confidence in your coding and documentation!
2016 Code Changes
Prolonged Services: 2016 UPDATE:

• **99354-99355** Prolonged practitioner E/M or *psychotherapy service(s)* (beyond the typical service time of the primary E/M or psychotherapy service) in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour (List separately in addition to code for office or other outpatient E/M (99201-99215, 99241-99245, 99324-99337, 99341-99350) or psychotherapy service 90837) – Billed by physicians, ARNPs or PAs
  
  • To bill practitioner prolonged codes must be > than 30 minutes associated with E/M

• **99415**: Prolonged clinical staff service (the service beyond the typical service time) during an E/M service in the office or outpatient setting, direct patient contact with physician supervision; first hour (List separately in addition to code for outpatient E/M service)
  
  • To bill clinical staff Prolonged codes, time starts at >45 minutes

• **99416**: Prolonged clinical staff service (the service beyond the typical service time) during an E/M service in the office or outpatient setting, direct patient contact with physician supervision; each additional 30 minutes (List separately in addition to code for prolonged service)
  
  • Do not bill 99416 with 99415
  
  • Do not bill 99415 or 99416 with 99354-99355

**NOTE:** Document what you did and how long you did it. If you are billing additional procedures, document the time and note that they are excluded from the prolonged service so double-dipping is not questioned. OUTPATIENT ONLY.

**REGULATIONS PER CMS:** The medical record must document by the practitioner to include the dated start and end times of the prolonged service.
Why Does Documentation Matter?

- It’s our agreement with Medicare and other insurance companies.
- Correct coding practice is part of good medical care.
- Civil and criminal violations are handed down each year for coding errors.
- Millions of dollars are lost each year to poor coding practices.
Inpatient and Outpatient Evaluation and Management E/M Documentation and Coding
The 3 Key Documentation Elements

History
Focus on HPI

Physical Exam

Medical Decision Making
Nuts and Bolts of E&M Coding

THE THREE KEY DOCUMENTATION ELEMENTS

MEDICAL DECISION-MAKING
HISTORY
PHYSICAL EXAM

How does medical necessity fit into these components?

Knowing the answer to this question will help you to select E/M codes and reduce audit risk.
Important!

• The **Nature of the Presenting Problem (NPP)** determines the level of documentation necessary for the service.

• The level of care (**E/M service**) submitted must not exceed the level of care that is medically necessary.

**SO . . .**

• Medical Decision-Making and Medical Necessity related to the “NPP” determine the maximum E/M service.

• The amount of history and exam should **NOT generally** alone.
Medical Decision Making (MDM)
DOCUMENT EVERYTHING THAT EFFECTS YOUR SERVICE TODAY!!

Step 1:
- Number of possible diagnoses and/or management options affecting today's visit. List each separately in A/P and address every diagnosis or management option from visit. Is the diagnosis and/or management options:
  - “New” self-limiting: After the course of prescribed treatment it is anticipated that the diagnosis will no longer be exist (e.g. otitis, poison ivy, …)
  - New diagnosis with follow-up or no follow-up: Diagnosis will remain next visit
  - Established diagnosis that stable or worse

Step 2:
- Amount and/or complexity of data reviewed, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed.
  - Labs, radiology, scans, EKGs etc. reviewed or ordered
  - Review and summarization of old medical records or request old records
  - Independent visualization of image, tracing or specimen itself (not simply review of report)

Step 3:
- The risk of significant complications, morbidity, and/or mortality with the patient’s problem(s), diagnostic procedure(s), and/or possible management options.
  - # of chronic conditions and are the stable or exacerbated (mild or severe)
  - Rxs ordered or renewed. Any Rx toxic with frequent monitoring?
  - Procedures ordered and patient risk for procedure

Note: The 2 most complex MDM steps out of the 3 will determine the overall level of MDM
1. Number of Diagnoses or Treatment Options

One or two stable problems?  
No further workup required?  
Improved from last visit?  

=  LOWER  
COMPLEXITY

Multiple active problems?  
New problem with additional workup?  
Are problems worse?  

=  HIGHER  
COMPLEXITY
### MDM Step 1: # Dx & Tx Options

#### Number of Diagnosis or Treatment Options – Identify Each That Effects Patient Care For The DOS

<table>
<thead>
<tr>
<th>Problem(s) Status</th>
<th>Number</th>
<th>Points</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-limited or minor (stable, improved or worsening)</td>
<td>Max=2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Est. Problem (to examiner) stable, improved</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Est. Problem (to examiner) worsening</td>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>New problem (to examiner); no additional workup planned</td>
<td>Max=1</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>New prob. (To examiner); additional workup planned</td>
<td></td>
<td>4</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1 POINT: E- 2, NEW-1,2 Sub IP – 1

2 POINTS: E-3, NEW-3 Sub IP – 1 Initial IP -1

3 POINTS: E-4, NEW-4 Sub IP - 2 Initial IP -2

4 POINTS or >: E-5, NEW-5 Sub IP – 3 Initial IP -3
Medical Decision-Making

2. Amount/Complexity of Data

- Were lab/x-ray ordered or reviewed?
- Were other more detailed studies ordered? (Echo, PFTs, BMD, EMG/NCV, etc.)
- Did you review old records?
- Did you view images yourself?
- Discuss the patient with consultant?
# MDM Step 2: Amt. & Complexity of Data

### Amount and/or Complexity of Data Reviewed – Total the points

<table>
<thead>
<tr>
<th>REVIEWED DATA</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review and/or order of clinical lab tests</td>
<td>1</td>
</tr>
<tr>
<td>Review and/or order of tests in the radiology section of CPT</td>
<td>1</td>
</tr>
<tr>
<td>Review and/or order of tests in the medicine section of CPT</td>
<td>1</td>
</tr>
<tr>
<td>Discussion of test results with performing physician</td>
<td>1</td>
</tr>
<tr>
<td>Decision to obtain old records and/or obtain history from someone other than patient</td>
<td>1</td>
</tr>
<tr>
<td>Review and summarization of old records and/or obtaining history from someone other than patient and/or discussion of case with another health care provider</td>
<td>2</td>
</tr>
<tr>
<td>Independent visualization of image, tracing or specimen itself (not simply review of report).</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
</tr>
</tbody>
</table>
3. Table of Risk

- Is the presenting problem self-limited?
- Are procedures required?
- Is there exacerbation of chronic illness?
- Is surgery or complicated management indicated?
- Are prescription medications being managed?
<table>
<thead>
<tr>
<th>Risk Level</th>
<th>Presenting Problem</th>
<th>Diagnostic Procedure(s) Ordered</th>
<th>Management Options Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Min</td>
<td>One self-limited / minor problem</td>
<td>Labs requiring venipuncture</td>
<td>Rest  Elastic bandages  Gargles  Superficial dressings</td>
</tr>
<tr>
<td>Low</td>
<td>2 or more self-limited/minor problems  1 stable chronic illness (controlled HTN)  Acute uncomplicated illness / injury (simple sprain)</td>
<td>Physiologic tests not under stress (PFT)  Non-CV imaging studies  Superficial needle biopsies  Labs requiring arterial puncture  Skin biopsies</td>
<td>OTC meds  Minor surgery w/no identified risk factors  PT, OT  IV fluids w/out additives</td>
</tr>
<tr>
<td>Low</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OP Level 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IP Sub 1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IP Initial 1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mod</td>
<td>1 &gt; chronic illness, mod. Exacerbation, progression or side effects of treatment  2 or more chronic illnesses  Undiagnosed new problem w/uncertain prognosis  Acute illness w/systemic symptoms (colitis)  Acute complicated injury</td>
<td>Physiologic tests under stress (stress test)  Diagnostic endoscopies w/out risk factors  Deep incisional biopsies  CV imaging w/contrast, no risk factors (arteriogram, cardiac cath)  Obtain fluid from body cavity (lumbar puncture)</td>
<td>Prescription meds  Minor surgery w/identified risk factors  Elective major surgery w/out risk factors  Therapeutic nuclear medicine  IV fluids w/additives  Closed treatment, FX / dislocation w/out manipulation</td>
</tr>
<tr>
<td>Mod</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OP Level 4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IP Sub 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IP Initial 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High</td>
<td>1 &gt; chronic illness, severe exacerbation, progression or side effects of treatment  Acute or chronic illnesses that may pose threat to life or bodily function (acute MI)  Abrupt change in neurologic status (TIA, seizure)</td>
<td>CV imaging w/contrast, w/risk factors  Cardiac electrophysiological tests  Diagnostic endoscopies w/risk factors</td>
<td>Elective major surgery w/risk factors  Emergency surgery  Parenteral controlled substances  Drug therapy monitoring for toxicity  DNR</td>
</tr>
<tr>
<td>High</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OP Level 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IP Sub 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IP Initial 3</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Draw a line down any column with 2 or 3 circles to identify the type of decision making in that column. Otherwise, draw a line down the column with the 2\textsuperscript{nd} circle from the left. After completing this table, which classifies complexity, circle the type of decision making within the appropriate grid.

### Final Result for Complexity

<table>
<thead>
<tr>
<th></th>
<th>Number diagnoses or treatment options</th>
<th>≤ 1 Minimal</th>
<th>2 Limited</th>
<th>3 Multiple</th>
<th>≥ 4 Extensive</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Highest Risk</td>
<td>Minimal</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
</tr>
<tr>
<td>B</td>
<td>Amount and complexity of data</td>
<td>≤ 1 Minimal or low</td>
<td>2 Limited</td>
<td>3 Multiple</td>
<td>≥ 4 Extensive</td>
</tr>
<tr>
<td>C</td>
<td>Type of decision making</td>
<td>STRAIGHT-FORWARD</td>
<td>LOW COMPLEX</td>
<td>MODERATE COMPLEX</td>
<td>HIGH COMPLEX</td>
</tr>
</tbody>
</table>
Medical Record Documentation

CMS:

“Each medical record shall contain sufficient, accurate information to identify the patient, support the diagnosis, justify the treatment, document the course and results, and promote continuity of care among health care providers”.
Ignoring how medical decision-making affects E/M leveling can put you at risk.

• According to the Medicare Claims Processing Manual, chapter 12, section 30.6.1:

  • Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT® code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported.

  • That is, a provider should not perform or order work (or bill a higher level of service) if it’s not “necessary,” based on the nature of the presenting problem.
Medical Necessity

• The definitions of medical necessity are important, but it’s how they get applied in the claims adjudication process that gives them shape.

• In other words, when it comes to selecting the appropriate level of care for any encounter, medical necessity trumps everything else, including the documentation of history, physical exam. For physicians this could mean that even “bullet-proof” documentation of these key components will not ensure protection if auditors find that the medical necessity is lacking.
Medical Necessity

• To ensure that the level of care you select matches the intrinsic medical necessity of the encounter, let the key component of medical decision making be your guide. Because it is based on the number and nature of the clinical problems as well as the risk to the patient, the complexity of your medical decision making may be a reliable surrogate for the vaguely defined concept of medical necessity.

• Practitioners often estimate the medical decision making early in the encounter before they start to document the history and exam. Let the medical decision making point you toward the appropriate code.
FOUR ELEMENTS of HISTORY

- Chief Complaint (CC:)
- History of Present Illness (HPI) location/quality/severity/duration/timing/context/modifying factors/associated symptoms
- Review of Systems (ROS)
- Past/Family/Social History (PFSHx)
History

1. **Chief Complaint**
   - Concise statement describing reason for encounter ("stomach pain,"", "follow-up diabetes")
   - Can be included in HPI

   **IMPORTANT:**
   - The visit is not billable if Chief Complaint is not somewhere in the note
   - Must be "follow-up" of ___________________________
2. The HPI is a chronological description of the patient’s illness or condition. The elements to define the HPI are:

- **Location:** Right lower quadrant, at the base of the neck, center of lower back
- **Quality:** Bright red, sharp stabbing, dull
- **Severity:** Worsening, improving, resolving
- **Duration:** Since last visit, for the past two months, lasting two hours
- **Timing:** Seldom, first thing in the morning, recurrent
- **Context:** When walking, fell down the stairs, patient was in an MVA
- **Modifying Factors:** Took Tylenol, applied cold compress: with relief/without relief
- **Associated Signs and Symptoms:** With nausea and vomiting, hot and flushed, red and itching

**TWO TYPES:**

**BRIEF** 1-3 elements above or status of 1-2 diagnosis or conditions

**EXTENDED** 4 or > elements above or status of 3 or > diagnosis or conditions
4. REVIEW OF SYSTEMS

14 recognized:

- Constitutional
- Psych
- Eyes
- Respiratory
- ENT
- GI
- CV
- GU
- Skin
- MSK
- Neuro
- Endocrine
- Heme/Lymph
- Allergy/Immunology

THREE TYPES:  
- PROBLEM PERTINENT  (1 SYSTEM)
- EXTENDED  (2-9 SYSTEMS)
- COMPLETE  (10 SYSTEMS)
3. **PAST, FAMILY, AND SOCIAL HISTORY**
   - Patient’s previous illnesses, surgeries, and medications
   - Family history of important illnesses and hereditary conditions
   - Social history involving work, home issues, tobacco/alcohol/drug use, etc.

**TWO TYPES:**

**PERTINENT:** 1 area (P, F or S) generally related to HPI

**COMPLETE:** All 3 (P, F and S) for New patient and Initial Hospital
   or 2 of 3 areas (P, F or S) for established pt.
PEARLS FOR HISTORY DOCUMENTATION:

• Must have PAST/FAMILY/SOCIAL history for comprehensive history (ALL THREE)

• Don’t forget 10-system review!

• You cannot charge higher than a level 3 new or consult visit without COMPREHENSIVE HISTORY
# Scoring E/M History

## CHIEF COMPLAINT:

<table>
<thead>
<tr>
<th>HPI (history of present illness) elements: (Extended also includes status of 3 or &gt; chronic conditions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location</td>
</tr>
<tr>
<td>Quality</td>
</tr>
</tbody>
</table>

## ROS (Review of systems):

<table>
<thead>
<tr>
<th>□ Constitutional (wt loss, etc)</th>
<th>Ears, nose, mouth, throat</th>
<th>□ GI</th>
<th>□ Integumentary (skin, breast)</th>
<th>Endo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eyes</td>
<td>Card/vasc</td>
<td>GU</td>
<td>Neuro</td>
<td>□ Hem/Lymph</td>
</tr>
<tr>
<td>Resp</td>
<td>□ MS</td>
<td>Psych</td>
<td>□ All/immuno</td>
<td>□ All others negative</td>
</tr>
</tbody>
</table>

| □ Pertinent to problem (1 system) | Extended (2-9 systems) | **** Complete |

## PFSH (past medical, family, social history) areas:

<table>
<thead>
<tr>
<th>Past history (the patient's past experiences with illness, operations, injuries and treatments)</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family history (a review of medical events in the patient's family, including diseases which may be hereditary or place the patient at risk)</td>
<td>Pertinent (1 history area)</td>
</tr>
<tr>
<td>Social history (an age appropriate review of past and current activities)</td>
<td>* Complete (2 or 3 history areas)</td>
</tr>
</tbody>
</table>

* Complete PFSH:

**10 or more systems, or some systems with statement all others neg.
<table>
<thead>
<tr>
<th>2 hx areas: a) Estab pts. Office (outpt) care; domiciliary care; home care b) Emergency dept c) Subsequent nursing facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 hx areas: a) New pts. Office (outpt) care; domiciliary care; home care b) Consultations c) Initial hospital care d) Hospital observation e) Comprehensive nursing facility assessments</td>
</tr>
</tbody>
</table>

| PROBLEM FOCUSED (PF) | EXP. PROB. FOCUSED (EPF) | DETAILED (D) | COMPREHENSIVE (C) |
Physical Examination

4 TYPES OF EXAMS

- Problem Focused (PF)
- Expanded Problem Focused (EPF)
- Detailed (D)
- Comprehensive (C)
## Coding 1995: Physical Exam

<table>
<thead>
<tr>
<th>BODY AREAS (BA):</th>
<th>CODING ORGAN SYSTEMS (OS):</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Head, including face</td>
<td>• Constitutional/General</td>
</tr>
<tr>
<td>• Neck</td>
<td>• Eyes</td>
</tr>
<tr>
<td>• Chest, including breast</td>
<td>• Ears/Nose/Mouth/Throat</td>
</tr>
<tr>
<td>and axillae</td>
<td>• Respiratory</td>
</tr>
<tr>
<td>• Abdomen</td>
<td>• Cardiac</td>
</tr>
<tr>
<td></td>
<td>• GI</td>
</tr>
<tr>
<td></td>
<td>• Genitalia, groin, buttocks</td>
</tr>
<tr>
<td></td>
<td>• Back, including spine</td>
</tr>
<tr>
<td></td>
<td>• Each extremity</td>
</tr>
<tr>
<td></td>
<td>• GU</td>
</tr>
<tr>
<td></td>
<td>• Musculoskeletal</td>
</tr>
<tr>
<td></td>
<td>• Skin</td>
</tr>
<tr>
<td></td>
<td>• Neuro</td>
</tr>
<tr>
<td></td>
<td>• Psychiatric</td>
</tr>
<tr>
<td></td>
<td>• Hematologic/Lymphatic</td>
</tr>
</tbody>
</table>
1995 and 1997 Exam Definitions

**Problem Focused (PF):** 99231, 99212 or 99201

- ‘95: Limited exam of the affected body area or organ system. (1 BA/OS)
- ‘97=Specialty and GMS: 1-5 elements identified by bullet.

**Expanded Problem Focused (EPF):** 99232, 99213 or 99202

- ‘95: Limited exam of affected BA/OS and other symptomatic/related OS. (2-7 BA/OS)
- ‘97=Specialty and GMS: At least 6 elements identified by bullet.

**Detailed (D):** 99233, 99221, 99214 or 99203

- ‘95: Extended exam of affected BA/OS and other symptomatic/related OS. (2-7 BA/OS)
- 97=Specialty: At least 12 elements identified by bullet (9 for eye and psyc)

**Comprehensive (C):** 99222, 99223, 99215 or 99204 and 99205

- ‘95: General multi-system exam (8 or more organ systems) or complete single organ system (a complete single organ system is undefined by CMS).
- ‘97=Specialty: All elements with bullet in shaded areas and at least 1 in non-shaded area.
New Patients

Patient not seen by you **or your billing group** in the past **three years** (as outpatient or inpatient)
Using Time to Code

• Time shall be considered for coding an E/M in lieu of H-E-MDM when > 50% of the total billable practitioner visit time is counseling/coordination of care (CCC.)
  • Time is only Face-to-face for OP setting
• Coding based on time is generally the exception for coding.
• It is typically used:
  • Significant exacerbation or change in the patient’s condition,
  • Non-compliance with the treatment/plan,
  • Counseling regarding previously performed procedures or tests to determine future treatment options, or
  • Behavior/school issues.

Required Documentation For Billing:

1. Total time of the encounter excluding separate procedure if billed
   • The entire time to prep, perform and communicate results of a billable procedure to a patient must be carved out of the E/M encounter time!
2. The amount of time dedicated CCC for that patient on that date of service. A template statement would not meet this requirement.
## Time-Based Billing for CCC

<table>
<thead>
<tr>
<th>Outpatient Counseling Time:</th>
<th>Inpatient Counseling Time:</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201 10 min</td>
<td>99221 30 min</td>
</tr>
<tr>
<td>99202 20 min</td>
<td>99222 50 min</td>
</tr>
<tr>
<td>99203 30 min</td>
<td>99223 70 min</td>
</tr>
<tr>
<td>99204 45 min</td>
<td>99231 15 min</td>
</tr>
<tr>
<td>99205 60 min</td>
<td>99232 25 min</td>
</tr>
<tr>
<td>99241 15 min</td>
<td>99233 35 min</td>
</tr>
<tr>
<td>99242 30 min</td>
<td>99251 20 min</td>
</tr>
<tr>
<td>99243 40 min</td>
<td>99252 40 min</td>
</tr>
<tr>
<td>99244 60 min</td>
<td>99253 55 min</td>
</tr>
<tr>
<td>99245 80 min</td>
<td>99254 80 min</td>
</tr>
<tr>
<td>99211 5 min</td>
<td>99255 110 min</td>
</tr>
<tr>
<td>99212 10 min</td>
<td></td>
</tr>
<tr>
<td>99213 15 min</td>
<td></td>
</tr>
<tr>
<td>99214 25 min</td>
<td></td>
</tr>
<tr>
<td>99215 40 min</td>
<td></td>
</tr>
</tbody>
</table>
Counseling/Coordination of Care CCC

Proper Language used in documentation of time:

• “I spent ____ minutes with the patient and family and over 50% was in counseling about her diagnosis, treatment options including _______ and _______.”

• “I spent ____ minutes with the patient and family more than half of the time was spent discussing the risks and benefits of treatment with......(list risks and benefits and specific treatment)”

• “This entire ______ minute visit was spent counseling the patient regarding ________ and addressing their multiple questions.

Total time spent and the time spent on counseling and/or coordination of care must be documented in the medical record.

Documentation must reflect the specific issues discussed with patient present.
Initial Inpatient and Observation:

**ALL Key Elements** must be met or exceeded and be medically necessary

<table>
<thead>
<tr>
<th>Key Elements</th>
<th>99221</th>
<th>99222</th>
<th>99223</th>
</tr>
</thead>
<tbody>
<tr>
<td>H – E - MDM</td>
<td>99218</td>
<td>99219</td>
<td>99220</td>
</tr>
<tr>
<td>CC</td>
<td>Always</td>
<td>Always</td>
<td>Always</td>
</tr>
<tr>
<td>History - HPI</td>
<td>4 +</td>
<td>4 +</td>
<td>4 +</td>
</tr>
<tr>
<td>History - ROS</td>
<td>2 – 9</td>
<td>10 +</td>
<td>10 +</td>
</tr>
<tr>
<td>History - PFSH</td>
<td>1 – 2</td>
<td>All</td>
<td>All</td>
</tr>
<tr>
<td>Exam</td>
<td>2 – 7 (DET)</td>
<td>8 + (COMP)</td>
<td>8 + (COMP)</td>
</tr>
<tr>
<td>MDM</td>
<td>SF/Low</td>
<td>Mod</td>
<td>High</td>
</tr>
<tr>
<td>Time</td>
<td>30 Min</td>
<td>50 Min</td>
<td>70 Min</td>
</tr>
</tbody>
</table>

**Initial Inpatient and Observation:**

**ALL Key Elements** must be met or exceeded and be medically necessary.

<table>
<thead>
<tr>
<th>Key Elements</th>
<th>99221</th>
<th>99222</th>
<th>99223</th>
</tr>
</thead>
<tbody>
<tr>
<td>H – E - MDM</td>
<td>99218</td>
<td>99219</td>
<td>99220</td>
</tr>
<tr>
<td>CC</td>
<td>Always</td>
<td>Always</td>
<td>Always</td>
</tr>
<tr>
<td>History - HPI</td>
<td>4 +</td>
<td>4 +</td>
<td>4 +</td>
</tr>
<tr>
<td>History - ROS</td>
<td>2 – 9</td>
<td>10 +</td>
<td>10 +</td>
</tr>
<tr>
<td>History - PFSH</td>
<td>1 – 2</td>
<td>All</td>
<td>All</td>
</tr>
<tr>
<td>Exam</td>
<td>2 – 7 (DET)</td>
<td>8 + (COMP)</td>
<td>8 + (COMP)</td>
</tr>
<tr>
<td>MDM</td>
<td>SF/Low</td>
<td>Mod</td>
<td>High</td>
</tr>
<tr>
<td>Time</td>
<td>30 Min</td>
<td>50 Min</td>
<td>70 Min</td>
</tr>
</tbody>
</table>
**Subsequent Inpatient or Observation Visit**

*2 of 3 Key Elements* must be met or exceeded and be medically necessary

<table>
<thead>
<tr>
<th>Key Elements</th>
<th>99231</th>
<th>99232</th>
<th>99233</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>H – E - MDM</strong></td>
<td>99224</td>
<td>99225</td>
<td>99226</td>
</tr>
<tr>
<td><strong>CC</strong></td>
<td>Always</td>
<td>Always</td>
<td>Always</td>
</tr>
<tr>
<td><strong>History - HPI</strong></td>
<td>1 – 3</td>
<td>1 – 3</td>
<td>4 +</td>
</tr>
<tr>
<td><strong>History - ROS</strong></td>
<td>None</td>
<td>1</td>
<td>2 – 9</td>
</tr>
<tr>
<td><strong>History - Interval</strong></td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td><strong>PFSH</strong></td>
<td></td>
<td></td>
<td>None</td>
</tr>
<tr>
<td><strong>Exam</strong></td>
<td>1 (PF)</td>
<td>2 – 7 (EPF)</td>
<td>2 – 7 (DET)</td>
</tr>
<tr>
<td><strong>MDM</strong></td>
<td>SF/Low</td>
<td>Mod</td>
<td>High</td>
</tr>
<tr>
<td><strong>Time</strong></td>
<td>15 Min</td>
<td>25 Min</td>
<td>35 Min</td>
</tr>
</tbody>
</table>
Consultations or New Patient Office Visits
ALL 3 Elements must be met or exceeded

<table>
<thead>
<tr>
<th>Element</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Level 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>CC</td>
<td>Always</td>
<td>Always</td>
<td>Always</td>
<td>Always</td>
<td>Always</td>
</tr>
<tr>
<td>HPI</td>
<td>1 – 3</td>
<td>1 – 3</td>
<td>4 +</td>
<td>4 +</td>
<td>4 +</td>
</tr>
<tr>
<td>ROS</td>
<td>None</td>
<td>1</td>
<td>2 – 9</td>
<td>10 +</td>
<td>10 +</td>
</tr>
<tr>
<td>PFSH</td>
<td>None</td>
<td>None</td>
<td>1 – 2</td>
<td>All</td>
<td>All</td>
</tr>
<tr>
<td>EXAM</td>
<td>1 (PF)</td>
<td>2 – 7 (EPF)</td>
<td>2 – 7 (DET)</td>
<td>8 + (COMP)</td>
<td>8 + (COMP)</td>
</tr>
<tr>
<td>MDM</td>
<td>SF</td>
<td>SF</td>
<td>Low</td>
<td>Mod</td>
<td>High</td>
</tr>
<tr>
<td>Time</td>
<td>N 10</td>
<td>N 20</td>
<td>N 30</td>
<td>N 45</td>
<td>N 60</td>
</tr>
<tr>
<td></td>
<td>C 15</td>
<td>C 30</td>
<td>C 40</td>
<td>C 60</td>
<td>C 80</td>
</tr>
</tbody>
</table>
## Established OP Visits – 2 of 3 Elements must be met

<table>
<thead>
<tr>
<th>Element</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Level 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>CC</td>
<td>* Dr. Presence</td>
<td>Always</td>
<td>Always</td>
<td>Always</td>
<td>Always</td>
</tr>
<tr>
<td>HPI</td>
<td>Presence</td>
<td>1 – 3</td>
<td>1 – 3</td>
<td>4+</td>
<td>4+</td>
</tr>
<tr>
<td>ROS</td>
<td>Not Required</td>
<td>None</td>
<td>1</td>
<td>2 – 9</td>
<td>10+</td>
</tr>
<tr>
<td>PFSH</td>
<td>Nurse Visit</td>
<td>None</td>
<td>None</td>
<td>1</td>
<td>2 – 3</td>
</tr>
<tr>
<td>EXAM</td>
<td>1 (PF)</td>
<td>2 – 7 (EPF)</td>
<td>2 – 7 (DET)</td>
<td>8 + (COMP)</td>
<td></td>
</tr>
<tr>
<td>MDM</td>
<td>SF</td>
<td>Low</td>
<td>Mod</td>
<td>High</td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>5 Min</td>
<td>10 Min</td>
<td>15 Min</td>
<td>25 Min</td>
<td>40 Min</td>
</tr>
</tbody>
</table>
TWO MIDNIGHT RULE DECISION TREE FOR MEDICARE PATIENTS

Does the physician expect the patient to require more than two midnights of hospital care that cannot be performed at a lower level of care? This includes care provided in the emergency room and/or if the patient is transferred to the hospital.

- **NO**
  - Is the patient receiving an Inpatient only procedure? (Consult case management)
    - **NO**
      - Is the patient newly ventilated? (Excluding ventilation during surgery)
        - **NO**
          - Write an order for Outpatient OR Outpatient Observation Status
        - **YES**
          - Write an Inpatient Order along with expected length of stay
    - **YES**
      - Write an Inpatient Order

- **YES**
  - Write an order for Inpatient Status: Document that the patient meets the two midnight benchmark, the expected length of stay and the medical necessity for inpatient care.

* If the physician writes an inpatient order and then after one day of treatment the patient can receive care at a lower level, change the status to observation with a condition code (44) through case management.

* If a patient discharges early because of death, leaving AMA, transferring to another facility or an unforeseen recovery, then the patient should remain in patient with supportive documentation.
Inpatient E/M Subsequent Hospital Coding

Inpatient Hospital

• Subsequent Hospital Care

  Three levels of service: 99231, 99232, 99233

• 99231 - Stable, recovering, improving
  • Problem focused history or exam

• 99232 - Not responding, minor complication
  • Expanded problem focused history or exam

• 99233 - Very unstable, significant complications
  • Detailed history or exam

REMEMBER: What is medically necessary to document for that day?
Subsequent Hospital Visits

Inpatient Hospital

Medical Necessity should drive your documentation for each day’s visit:

What’s wrong with this audit?

Day 1: 99223
Day 2: 99233
Day 3: 99233
Day 4: 99233
Day 5: 99233
Day 6: 99239 (discharge to home)
Hospital Discharge

IMPORTANT!

• Documentation should include:
  • final examination of patient
  • discharge instructions/follow-up
  • preparation of referrals/prescriptions
  • time spent

• If less than 30 minutes: 99238
• If more than 30 minutes: 99239 (TIME must be documented)
USING DIFFERENT LEVELS OF CARE

99223 *  
PATIENT ADMITTED

99233 *  
(PATIENT IS UNSTABLE)

99232 *  
(PATIENT HAS DEVELOPED MINOR COMPL.)

99231 *  
(PATIENT IS STABLE, RECOVERING, IMPROVING)

99238 *  
PATIENT DISCHARGED
Hospital Observation Services

• Admission/Discharge on different days:
  • 99218: Detailed history/exam, low-complexity MDM
  • 99219: Comprehensive history/exam, moderate MDM
  • 99220: Comprehensive history/exam, high MDM
  • 99217: Observation Discharge

• Admission/Discharge on same day:
  • 99234: Detailed history/exam, low-complexity MDM
  • 99235: Comprehensive history/exam, moderate MDM
  • 99236: Comprehensive history/exam, high MDM

Subsequent Observation: 99224, 99225, 99226 (New 2011)
Inpatient Hospital Dialysis
Inpatient Hospital Dialysis

90935: Hemodialysis, one evaluation
   • 90937: Hemodialysis, repeated eval

90945: Dialysis, one evaluation - other than hemodialysis (eg, peritoneal dialysis, hemofiltration, or other continuous renal replacement therapies)
   • 90947: Dialysis, repeated eval

90935 and 90945 (single evaluation) represent a standard "uncomplicated" dialysis session.

90937 and 90947 (repeated evaluations, with or without substantial revision of dialysis prescription) represent a "complicated" dialysis session.
   • The physician may visit the patient several times during a session and may also adjust the dialysis prescription.

For inpatient dialysis, the physician must be physically present with the patient some time during the course of the dialysis procedure and this must be documented in the medical records.
• Dialysis codes include payment for any E/M services that are related to the patient’s renal disease and are provided on the same date as the dialysis service is provided and billed.

• Payment for all E/M services are bundled into the payment for 90935, 90937, 90945, and 90947, unless:
  • Service is significant and separately identifiable
  • Meets medical necessity requirements to bill

• If the physician visits the dialysis inpatient on a dialysis day, but not during the dialysis treatment, bill a hospital visit and not a dialysis code.
Per National Correct Coding 1/1/16 pages 11 & 46

- Renal dialysis procedures coded as CPT codes 90935, 90937, 90945, and 90947 include E/M services related to the dialysis procedure and the renal failure.

- If the physician additionally performs on the same date of service medically reasonable and necessary E/M services unrelated to the dialysis procedure or renal failure that are significant and separately identifiable, these services may be separately reportable.

- CMS allows physicians to additionally report if appropriate CPT codes 99201-99215, 99221-99223, 99238—99239, and 99291-99292.

- These codes must be reported with modifier 25 if performed on the same date of service as the dialysis procedure.
The Medicare Carrier’s Manual Section 15062.1 states:

90935 / 90945: The physician must have been physically present with the patient at some time during the course of the dialysis, and the medical record must document this.

90937 / 90947: The physician must document repeated visits with the patient during the course of the dialysis, and the medical record must document that the physician’s repeated evaluation of patients during the hemodialysis procedure was medically necessary [MCM '15062.1.A.1 and 15062.1.C.1]. Example: Vital sign changes requiring physician intervention and Tx changes
Monthly Capitation Payment (MCP)
90951-90962 are reported once per month to distinguish age-specific services related to the patient's ESRD performed in an outpatient setting with three levels of service based on the # of face-to-face visits.

ESRD-related physician services include establishment of a dialyzing cycle, outpatient evaluation and management of the dialysis visits, telephone calls, and patient management during the dialysis provided during a full month.

In the circumstances where the patient has had a complete assessment visit during the month and services are provided over a period of less than a month, 90951-90962 may be used according to the number of visits performed.

• Evaluation and Management services unrelated to ESRD services that cannot be performed during the dialysis session may be reported separately.
What’s NOT Included in MCP?

Surgical services such as:
• Temporary or permanent hemodialysis catheter placement
• Temporary or permanent peritoneal dialysis catheter placement
• Repair of existing dialysis accesses
• Placement of catheter(s) for thrombolytic therapy
• Thrombolytic therapy (systemic, regional, or access catheter only; hemodialysis or peritoneal dialysis)
• Thrombectomy of clotted cannula
• Arthrocenteses
• Bone marrow aspiration
• Bone marrow biopsy
What’s NOT Included in MCP?

• Interpretation of tests that have a professional component such as:
  • Electrocardiograms (12 lead, Holter monitor, stress tests, etc.)
  • Echocardiograms
  • 24-hour blood pressure monitor
  • Spirometry and complete pulmonary function tests; and
  • Biopsies

  ▪ Complete evaluation for renal transplantation
  ▪ Evaluation of potential living transplant donors
  ▪ Non-renal related physician’s services
  ▪ Covered physician services furnished to hospital inpatients, including:
    ▪ Services related to inpatient dialysis, by a physician who elects not to continue to receive the MCP during the period of inpatient stay
<table>
<thead>
<tr>
<th>MCP CPT Code</th>
<th>Patient Age</th>
<th># of Face to Face Visits</th>
<th>Home Dialysis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>90953</td>
<td>&lt; 2</td>
<td>One Visit</td>
<td><strong>90963</strong> End-stage renal disease (ESRD) related services for home dialysis per full month, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents</td>
</tr>
<tr>
<td>90952</td>
<td>2 to 3</td>
<td></td>
<td><strong>90964</strong> End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents</td>
</tr>
<tr>
<td>90951</td>
<td>4+</td>
<td></td>
<td><strong>90965</strong> End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents</td>
</tr>
<tr>
<td>90956</td>
<td>2 to 11</td>
<td>One Visit</td>
<td><strong>90966</strong> End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 20 years of age and older</td>
</tr>
<tr>
<td>90955</td>
<td>2 to 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>90954</td>
<td>4+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>90959</td>
<td>12 to 19</td>
<td>One Visit</td>
<td></td>
</tr>
<tr>
<td>90958</td>
<td>2 to 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>90957</td>
<td>4+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>90962</td>
<td>20+</td>
<td>One Visit</td>
<td></td>
</tr>
<tr>
<td>90961</td>
<td>2 to 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>90960</td>
<td>4+</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
CPT Codes 90967 – 90970

For reporting purposes, each month is considered 30 days

- ESRD services for less than a full month of service, per day, for services provided under the following circumstances:
  - home dialysis patients less than a full month,
  - transient patients,
  - partial month where there was one or more face-to-face visits without the complete assessment,
  - the patient was hospitalized before a complete assessment was furnished,
  - dialysis was stopped due to recovery or death, or the patient received a kidney transplant.

- **90967**: ESRD related services for dialysis less than a full month of service, per day; for patients younger than 2 years of age

- **90968**: 2-11 years of age

- **90969**: 12-19 years of age

- **90970**: 20 years of age and older
**Modifiers**

- Indicate that a separate service or procedure has been performed by the same physician on the same day (2 CPT codes submitted)

- **Medicare is monitoring these codes!**

- Recent report from CMS: 35% of claims using modifier -25 did not meet requirements, resulting in $538 million dollars in improper payments

**You will be audited if you regularly use these codes! Ensure documentation supports the E/M and significant separate procedure.**
Common Modifiers

**Modifier -25**

- Signifies visit or consultation for a SIGNIFICANT, SEPARATE identifiable E/M service on the same day

- Example - visit for HTN, DM follow-up/patient also receives injection in knee
Teaching Physicians (TP) Guidelines

Billing Services When Working With Residents, Fellows, and Interns

All Types of Services Involving a resident with a TP Requires Appropriate Attestations In EHR or Paper Charts To Bill
Evaluation and Management (E/M)

**E/M IP or OP:** TP must **personally document by a personally selected macro in the EMR or handwritten** at least the following:

- That s/he was **present** and performed key portions of the service in the presence of or at a separate time from the resident; **AND**
- The **participation** of the teaching physician in the management of the patient.

- **Initial Visit:** “I saw and evaluated the patient. I reviewed the resident’s note and agree, except that the picture is more consistent with an upper respiratory infection not pneumonia. Will begin treatment with........”

- **Initial or Follow-up Visit:** “I saw and evaluated the patient. Discussed with resident and agree with resident’s findings and plan as documented in the resident’s note.”

- **Follow-up Visit:** “See resident’s note for details. I saw and evaluated the patient and agree with the resident’s finding and plans as written.”

- **Follow-up Visit:** “I saw and evaluated the patient. Agree with resident’s note, but lower extremities are weaker, now 3/5; MRI of L/S Spine today.”

The documentation of the Teaching Physician must be patient specific.
Unacceptable TP Documentation

• Assessed and Agree
• Reviewed and Agree
• Co-signed Note
• Patient seen and examined and I agree with the note
• As documented by resident, I agree with the history, exam and assessment/plan
Evaluation and Management (E/M)

**Time Based E/M Services:** The TP must be present and document for the period of time for which the claim is made. Examples:

- Critical Care Hospital Discharge (>30 minutes) or
- E/M codes where more than 50% of the TP time spent counseling or coordinating care

Medical Student documentation for billing only counts for ROS and PFSH. All other contributions by the medical student must be re-performed and documented by a resident or teaching physician.
MLN Matters Number: MM5932

- TP presence policy applies to ESRD-related visits furnished under the MCP. This means that patient visits furnished by residents may be counted toward the MCP visits if the teaching MCP physician is physically present during the visits.
  - The teaching physician may utilize the resident’s notes, however, the physician must document his or her physical presence and participation during the visit(s) furnished by the resident and that he or she reviewed the resident’s notes and agree or made changes.

- MCP practitioner must furnish at least one patient visit per month to receive payment for the MCP service (center based patients). This means, as the TP, you may count the patient visits that residents furnish toward the MCP visits if you are physically present during the visit.
TP Guidelines for Procedures

Minor – (< 5 Minutes): For payment, a minor procedure billed by a TP requires that s/he is physically present during the entire procedure.

Example: ‘I was present for the entire procedure.’

Major – (>5 Minutes)

• SINGLE Procedure / Surgery — When the teaching surgeon is present or performs the procedure for a single non-overlapping case involving a resident, he/she or the resident can document the TP’s physical presence and participation in the surgery.

Example: “I was present for the entire procedure (or key and critical portions & description of the key and critical portions of the procedure and immediately available).”

Endoscopy Procedures (excluding Endoscopic Surgery):

TP must be present during the entire viewing for payment.

• The viewing begins with the insertion and ends with the removal.
• Viewing of the entire procedure through a monitor in another room does not meet the presence requirement.
• TEACHING PHYSICIANS WHO SEEK REIMBURSEMENT FOR OVERSIGHT OF PATIENT CARE BY A RESIDENT MUST PERSONALLY SUPERVISE ALL SERVICES PERFORMED BY THE RESIDENT.

• PERSONAL SUPERVISION PURSUANT TO RULE 59G-1.010(276), F.C.A, MEANS THAT THE SERVICES ARE FURNISHED WHILE THE SUPERVISING PRACTITIONER IS IN THE BUILDING AND THAT THE SUPERVISING PRACTITIONER SIGNS AND DATES THE MEDICAL RECORDS (CHART) WITHIN 24 HOURS OF THE PROVISION OF THE SERVICE.
High-Risk Procedures & Diagnostic Services

**Complex or high-risk procedures:** Requires personal (in person) supervision of its performance by a TP and is billable only when the TP is present with the resident for the entire procedure. These procedures typically include cardiac and other interventional services.

- Example: “Dr. TP (or I) was present for the entire (identify procedure).”

**Diagnostic services with an interpretation:** If documented by a resident to be billed by a TP requires that s/he personally document that s/he personally reviewed the images, tracing, slides etc. and the resident’s interpretation and either agrees with it or edits the findings.

- Example: “I personally reviewed the films (and/or slides etc.) and agree with the resident’s findings.”
Orders” Are Required For Any Diagnostic Procedure With a TC / 26 Modifier

• The CPT descriptions of documentation requirements for many ophthalmic diagnostic tests include the phrase, ".

• . . with interpretation and report." Once the appropriate individual has performed the test, you must document your interpretation of the results somewhere in the medical records. This doesn't have to be anything elaborate.

• It may merely be a brief phrase indicating if a test is "normal," "stable from a previous test" or "mild superior arcuate defect."
Top Ten Compliance Issues For Documenting in EMR
Documentation in EMR

CMS IS WATCHING EMR DOCUMENTATION

Once you sign your note, YOU ARE RESPONSIBLE FOR ITS CONTENT
Documentation in EMR

• Every exam component . . .

• Every time you copy forward Family/Social History . . .

• Every HPI and ROS item you document means YOU PERFORMED THEM ON THAT VISIT . . .

• If you document something you did not do . . .

YOU ARE PUTTING YOURSELF AND THE INSTITUTION AT GREAT RISK!
Top Ten Compliance Rules for EMR

1. Use “Copy Forward” with caution

- Each visit is unique

- **Cloned documentation** is very obvious to auditors

- If you bring a note forward it MUST reflect the activity for the CURRENT VISIT with appropriate editing

- **Strongly advise** NOT copying forward HPI, Exam, and complete Assessment/Plan
NOTE 06/05/12
69 y.o. WF with newly diagnosed Stage III-IV breast cancer with chest wall mass on the L and subareolar mass on the R with discordant pathology. **Patient has not undergone metastatic evaluation yet.**
- CT of Chest/Abdomen and Pelvic as well as echocardiogram
- After imaging complete, will start chemotherapy
- After 4 rounds of chemotherapy, proceed with resection of both masses
- Will need further chemotherapy and XRT after surgery

**HPI States:** “She had a metastatic evaluation on Friday and we will review that together today”

NOTE 06/26/12
69 y.o. WF with newly diagnosed Stage III-IV breast cancer with chest wall mass on the L and subareolar mass on the R with discordant pathology. **Patient has not undergone metastatic evaluation yet.**
- CT of Chest/Abdomen and Pelvic as well as echocardiogram
- After imaging complete, will start chemotherapy
- After 4 rounds of chemotherapy, proceed with resection of both masses
- Will need further chemotherapy and XRT after surgery

**HPI States:** “She had a metastatic evaluation on Friday and we will review that together today.”

“Here for 2nd neoadj chemo for bilat breast cancer”

NOTE 08/06/12
69 y.o. WF with newly diagnosed Stage III-IV breast cancer with chest wall mass on the L and subareolar mass on the R with discordant pathology. **Patient has not undergone metastatic evaluation yet.**
- CT of Chest/Abdomen and Pelvic as well as echocardiogram
- After imaging complete, will start chemotherapy
- After 4 rounds of chemotherapy, proceed with resection of both masses
- Will need further chemotherapy and XRT after surgery

Diagnosis and treatment plan discussed with patient and her husband who expressed understanding.

**HPI States:** “She had a metastatic evaluation on Friday and we will review that together today.”

“Here for 4th neoadj chemo for bilat breast cancer”
Top Ten Compliance Rules for EMR

2. Don’t dump irrelevant information into your note
   • (“the 10-page follow-up note”)
   • Be judicious with “Auto populate”
   • Consider Smart Templates instead
   • Marking “Reviewed” for PFSHx or labs is OK from Compliance standpoint (as long as you did it!)
Top Ten Compliance Rules for EMR

3. Never copy ANYTHING from one patient’s record into another patient’s note

• Self-explanatory
4. Only Past/Family/Social History and Review of Systems may be used from a medical student or nurse’s note

- Student or nurse may start the note
- Provider (resident or attending)
- must document HPI, Exam, and
- Assessment/Plan
Top Ten Compliance Rules for EMR

5. Never copy documentation from another provider without clearly identifying the original author

• Can be considered a false claim

• Not always easy to do – better to avoid
Top Ten Compliance Rules for EMR

6. Utilize Approved Attestations for resident/fellow/mid-level provider notes

• Important that both providers are identified in the note

• “Auto-Text” makes this a 2-click process
7. Be careful with pre-populated “No” or “Negative” templates

• Cautious with ROS and Exam

• Macros, Check-boxes, or Free Text are safer and more individualized
Top Ten Compliance Rules for EMR

8. Authenticate all documentation and orders per policy

- 48 hours for verbal orders
- 30 days for signed documentation
Top Ten Compliance Rules for EMR

9. Link diagnosis to each test ordered (lab, imaging, cardiographics, referral)

• Demonstrates Medical Necessity

• Know your covered diagnoses for your common labs
Top Ten Compliance Rules for EMR

10. Individualize every note with a focus on the HPI and Medical Decision Making

• Results is correct coding with the focus of an E/M selection on medical necessity
Redemption Tips for Copy and Paste Physicians
Copy/Paste Philosophy:

*Your note should reflect the reality of the visit for that day*
Use Specific Dates

• Don’t say Today, Tomorrow, or Yesterday

• Write specific dates, i.e., “ID Consult recommends ceftriaxone through 9/3”, instead of “six more days”, which could be carried forward inaccurately

• “Heparin stopped 6/20 due to bleeding” will always be better than “Heparin stopped yesterday”, which can be carried forward in error
Use Past Tense

- “Neuro status remains stable, will discontinue neuro checks” can be copied forward in error

- Better – “Neuro checks stopped on 2/24”

- “Added heparin on 4/26” – uses past tense and specific date for better accuracy
Avoid the use of “I” Unless in Attestation

• Avoid personal pronouns except attestations

• “I discussed code status with Ms. Smith and she requested to be DNR” could be copied forward by someone else

• “Code status discussed with Ms. Smith and she requested to be DNR” will always be acceptable and true
Refresh/Update HPI Everyday

- Progressive cumulative daily HPIs become unreadable and cumbersome
- Temptation exists to add no new information
- If a previous HPI is needed, it is easily found in the EMR on a past note
Delete the Prior Review of Systems

**DO NOT COPY FORWARD REVIEW OF SYSTEMS!**

- This leads to contradictions and inconsistency, and danger of documenting something you didn’t do

- HPI – "**Patient reports nausea this morning**”
  - Templated ROS same day "**No nausea, no vomiting**”
Document the Exam ACTUALLY PERFORMED

• Always better to document “fresh” exam every day

• If copied forward or templated, review the exam closely and make corrections to items you did not perform

• Credibility is questioned when ear exam is documented every day, or when amputee has “2+ pulses in bilateral lower extremities”
Avoid Routine Daily Labs and Vitals in Each Note

- These already exist in the EMR
- Summarize in the Assessment/Plan
- These can create unnecessary volumes of pages in notes each day
- Labs and imaging reports are not necessary for billing
Do Not Use “Pending” for Consult Requests

Instead, put specific date requested:

• “Cardiology consult requested 3/22 at 4pm”

• This provides a legal safeguard in case of a poor outcome, as well as being accurate

• “Pending” can be copied forward for days in error
Copy / Paste Summary

• Copy/Paste can be a valuable tool for efficiency when used correctly

• There are major Compliance risks when used inappropriately, including potential fraud and abuse allegations, denial of hospital days, and adverse patient outcomes

• Make sure your note reflects the reality and accuracy of the service each day
CASE SAMPLES
“Whoa—way too much information.”
HIPAA, HITECH, PRIVACY AND SECURITY

• HIPAA, HITECH, Privacy & Security Health Insurance Portability and Accountability Act – HIPAA
  – Protect the privacy of a patient’s personal health information
  – Access information for business purposes only and only the records you need to complete your work.
  – Notify Office of HIPAA Privacy and Security at 305-243-5000 if you become aware of a potential or actual inappropriate use or disclosure of PHI, including the sharing of user names or passwords.
  – PHI is protected even after a patient’s death!!!

• Never share your password with anyone and no one use someone else’s password for any reason, ever – even if instructed to do so.

✓ If asked to share a password, report immediately.
✓ If you haven’t completed the HIPAA Privacy & Security Awareness on-line CBL module, please do so as soon as possible by going to:

http://www.miami.edu/index.php/professional_development__training_office/learning/ulearn/
• HIPAA, HITECH, Privacy & Security
• Several breaches were discovered at the University of Miami, one of which has resulted in a class action suit. As a result, “Fair Warning” was implemented.

• What is Fair Warning?
• • Fair Warning is a system that protects patient privacy in the Electronic Health Record by detecting patterns of violations of HIPAA rules, based on pre-determined analytics.
• • Fair Warning protects against identity theft, fraud and other crimes that compromise patient confidentiality and protects the institution against legal actions.
• • Fair Warning is an initiative intended to reduce the cost and complexity of HIPAA auditing.
• UHealth has policies and procedures that serve to protect patient information (PHI) in oral, written, and electronic form. These are available on the Office of HIPAA Privacy & Security website: http://www.med.miami.edu/hipaa
Available Resources at University of Miami, UHealth and the Miller School of Medicine

• If you have any questions or concern regarding coding, billing, documentation, and regulatory requirements issues, please contact:
  • Gemma Romillo, Assistant Vice President of Clinical Billing Compliance and HIPAA Privacy; or
  • Iliana De La Cruz, RMC, Director Office of Billing Compliance
    • Phone: (305) 243-5842
    • Officeofbillingcompliance@med.miami.edu

• Also available is The University’s fraud and compliance hotline via the web at www.canewatch.ethicspoint.com or toll-free at 877-415-4357 (24 hours a day, seven days a week).

• Office of billing Compliance website: www.obc.med.miami.edu