Clinical Documentation Improvement

By: Quita Edwards, CPC, CPMA, CPC-I, COSC

Disclaimer

This course was current at the time it was published. This course was prepared as a tool to assist the participant in educating providers and is not intended to grant rights or impose obligations. Although every reasonable effort has been made to assure the accuracy of the information within these pages, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services. AAPC employees, agents, and staff make no representation, warranty, or guarantee that this compilation of information is error-free and will bear no responsibility or liability for the results or consequences of the use of this course. This guide is a general summary that explains commonly accepted aspects of selecting Evaluation and Management (E/M) codes, but it is not a legal document. View points are discussed from the standpoint of the 1995 and 1997 Centers for Medicare and Medicaid Services (CMS) Evaluation and Management Documentation Guidelines with medical necessity and the nature of the presenting problem as the primary criterion of code selection (Medicare Claims Processing Manual Chapter 12—Physicians/Nonphysician Practitioners, 30.6.1—Selection of Level of Evaluation and Management Service, A. Use of CPT® Codes.) For the purpose of objective consistency, specific logics are primarily based on the same used by the E/M Documentation Auditors' Worksheet, Marshfield Clinic, available through the *Medical Group Management Association (MGMA)*. Specific payers, including Medicare Carriers, may use different and sometimes varied audit tools logics to gain objective consistency around the 95 and 97 Documentation Guidelines. Official provisions are contained in the relevant laws, regulations, rulings and contractual agreements of providers.

Notices

It is recommended that the participant of this course will be familiar with:

- 1995 Documentation Guidelines for Evaluation and Management Services
- 1997 Documentation Guidelines for Evaluation and Management Services

These may be downloaded from the CMS website at: www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp

Notice Regarding Clinical Examples Used in this Book

AAPC believes it is important in training and testing to reflect as accurate a coding setting as possible to students and examinees. All examples and case studies used in our study guides and exams are actual, redacted office visit and procedure notes donated by AAPC members.

To preserve the real world quality of these notes for educational purposes, we have not rewritten or edited the notes to the stringent grammatical or stylistic standards found in the text of our products. Some minor changes have been made for clarity or to correct spelling errors originally in the notes, but essentially they are as one would find them in a coding setting.

2480 South 3850 West, Suite B, Salt Lake City, Utah 84120

800-626-CODE (2633), Fax 801-236-2258, www.aapc.com

Contents

Introduction

Clinical documentation improvement is a prevailing topic in the health care industry. Clinical documentation is the catalyst for coding, billing, and auditing, and is the conduit for (and provides evidence of) the quality and continuity of patient care. This program is designed to provide a true representation of the impact clinical documentation has in the health care industry, and to emphasize the critical characteristics of documentation.

Coding and reimbursement professionals are at the center of clinical documentation improvement. This aspect of health care services not only includes coding and billing, but reaches beyond to include the documentation of quality of care.

Clinical documentation improvement is a proactive measure. There must be consistency and attention to detail to improve clinical documentation. The focus of documentation improvement should not be solely directed on reimbursement. As reimbursement models shift from fee for service to quality of care and patient outcomes, there is a need to efficiently communicate the quality of care provided and patient outcomes associated with that care.

Much like the designation of a HIPAA compliance officer, every office/facility should have a designated Clinical Documentation Specialist (CDS). Job titles may vary for this position. For example, other common job titles include Quality Assurance Auditors, Quality Improvement Auditors, and Clinical Record Auditors. Throughout this presentation, it will be referred to as CDS.

If the practice is relatively large, a team of individuals, working together for the purpose of Clinical Documentation Improvement, (CDI), can manage compliance. The CDS must be knowledgeable in the specialty, and able to understand the requirements for coding and reporting within that specialty. The CDS must also be proficient in the specialty's terminology, anatomy, and pathophysiology.

The CDS will develop and monitor policies and procedures that affect the documentation process. Practices or facilities may have different needs because of different specialties and services provided. CDI should begin at the front end of all services and care. Prevention of documentation issues is the key. CDS will work with all individuals within the practice who play a role in the documentation process.

The Professional Side of Clinical Documentation

The need for analyzing clinical documentation beyond coding and reimbursement becomes more evident every day. There is a heightened awareness and demand for clinical documentation improvement. Reasons why include:

- Patient involvement—more patients are requesting their medical records. Visit summaries are provided to the patients as part of meaningful use.
- Increasing regulatory demands for evidence based patient care.
- Increasing use of the electronic medical record (EMR), including issues involved with implementing the EMR and the need for continuous accuracy and EMR compliance.
- More frequent audits performed with the intent to recover payments.
- The health care industry, with the use of the electronic resources, can now afford to aggressively investigate and enforce compliance through audits, recoupment, and denial of payments.

These and other demands are creating a tremendous compliance burden for all health care providers, while broadening the scope and responsibilities of coding and auditing professionals.

Coding professionals and auditors already perform many aspects of the clinical documentation improvement and will continue to do so; coders and auditors will be required to become more proficient within their specialty to facilitate the quality of information documented for each encounter.

As coders and auditors, we look at documentation to determine the services that should be billed. CDS looks at the documentation to determine how to improve documentation to accurately communicate the patient care, adhere to regulatory requirements (e.g., consent forms for treatment are signed), as well as what should be documented to support services.

In smaller practices and entities, the auditors and coding staff may have the responsibility of performing the CDI, as well. Unfortunately, often the auditor or coding specialist is charged with performing all of these requirements, wearing many hats as he or she strives for compliance, practice- or facility-wide.

In large practices or facilities, the responsibility of documentation improvement for patient care and quality assurance is carved out of the coding and billing departments. The increasing volume of work with coding, billing, and auditing is reshaping the workflow, as well. The changes in health care and technology are requiring a central focus on CDI, working prospectively.

Clinical documentation will always be an inherent part of coding and auditing; however, industry changes require additional objectives for the auditing of the medical record. The demand for coders, auditors, and CDS is the result of all of these industry changes. Health care and the responsibilities of the professionals working within the "Business Side of Medicine" continuously evolve, requiring the skilled auditor, coding professionals, and CDS to work as a team to facilitate effective change where needed and to identify and manage all issues concerning clinical documentation.

Agenda

Clinical Documentation Improvement

- The role of the CDS
- The Quality of Documentation
- The Electronic Medical Record
- Mastering the Documentation Process
- The Impact of ICD-10 on Clinical Documentation
- Coding and Abstracting
- Implementation of a CDI program
- Hands-on Activities

Chapter 1:

The Role of the Clinical Documentation Specialist

Many large practices or facilities will employ a CDS to work in tandem with auditors and coding professionals. The responsibilities of the CDS and an auditor may overlap; however, there are fundamental differences in the responsibilities of an auditor and a CDS.

- Auditors review the record for documentation to support the CPT® and ICD-9-CM codes selected, and the coding and billing processes, after the claims have been submitted.
- Auditors routinely run frequency reports for code utilization compared to national, state, or specialty benchmarks. Developing reports related to the audit findings are routine, as well.
- Auditors watch for coding and documentation deficiencies that cause financial impact (overcoding or undercoding).
- Auditors analyze data for missed charges.
- Auditors provide education based on audit findings to the staff and providers.

The CDS looks at the record with a different objective. The CDS' responsibilities will be more proactive, such as:

Developing and/or monitoring internal protocols for the staff responsible for entering patient and insurance data.

Performing Ongoing Reviews for Accurate Data Entry.

Establishing, maintaining, and monitoring policies and procedures to reduce risk. For example:

- Patient instructions, and documentation that the patient understands the instructions
- Informed consents
- Assignment of benefits
- ABN utilization
- HIPAA consent
- Patient intake forms and updates
- Patient signatures and completion of forms
- Medication lists updates
- Allergies updates
- Quality of care indicators
- The use of acronyms
- Correcting a deficient record
- Note cloning

This list is not all-inclusive. One can see the need for a team and thorough communication with support staff and providers to accomplish the tasks.

Monitoring the timeliness of the documentation is important. Providers who are habitually late with documentation may leave out the details needed for patient-centered documentation.

The CDS will review the findings of the auditor to determine what should be done to remedy the issues. Each practice/facility will be different, according to specialty and issues or improper trends that present.

The CDS may have the responsibility of educating the providers on the medical necessity requirements, the limitations, and documentation requirements of a given procedure or service. The CDS will review the records for quality of content, structure and technical issues within the record.

He or she will review record for comprehensiveness, answering questions such as:

- Can the record stand alone?
- Does the information in the record show evidence of the nature and severity of the problem?
- Is there evidence of the services rendered and charges reported?
- Is the provider's assessment and plan complete enough for another clinician to take over the case?
- If the record were evidence in court, would it be comprehensive enough to support and protect the provider?

The CDS must also be able to train providers on the importance of "detailed" and "quality" documentation. Most providers have an inherent knowledge of what should be documented for clinical standards; however, there is a gap between clinical standards and the coding systems and published medical necessity requirements. Most providers document reasonably well for medical care, but are unaware of the details needed for accurate code selection for billing and reimbursement purposes.

Adding to this mix is the evolving technology, and regulatory requirements for quality of care and evidence of care. "Inherent knowledge" will no longer be enough.

As mentioned before, the medical record serves a multitude of purposes. The CDS plays a vital role in ensuring providers are documenting appropriately for ALL aspects of the health care industry.

"If it isn't documented, it's not done."

"The failure of a physician practice to: (i) document items and services rendered; and (ii) properly submit the corresponding claims for reimbursement is a major area of potential erroneous or fraudulent conduct involving Federal health care programs. The OIG has undertaken numerous audits, investigations, inspections and national enforcement initiatives in these areas."

Federal Register/*Vol. 65, No. 194/Thursday, October 5, 2000/Notices Page 59439*

How many times have we heard this statement? Most of the time, what we see happen is the provider definitely performed the services; however, he or she failed to properly document what was done.

For many different reasons, failure to accurately document is a daily occurrence, another reason for the heightened emphasis on clinical documentation improvement. If providers were documenting appropriately for the services rendered and billed, there would be no need for the emphasis on education, nor would payers employ entire departments whose only task is to audit the documentation associated with claims and services rendered. Coding and reporting must be accurate to have the claim paid.

If medical necessity requirements, limitations of coverage and documentation requirements are not met, the payer may ask for a recoupment of overpayment. Claims may meet the "technical" coding requirements; however, the documentation fails to meet the medical necessity for the services rendered or ordered.

Chapter 2:

The Quality of Documentation

Quality assurance in patient care is only evident if it is documented in the medical record. Quality services may have been provided; however, if this is not evident within the medical record, problems may arise.

For example, another provider (or the same provider several weeks later) will not necessarily know the details of the previous encounter. Providers can't always rely on the patient to fill them in. For example, the provider may ask the patient what medications she is taking, and the patient responds, "I take the purple one in the morning." If the provider has not documented the type of medication and proper dose in the patient's record, he will have no idea what the patient is taking and whether she is taking it correctly.

If the provider instructs the patient on risks and benefits of a procedure and how to properly take medication, but fails to document the instructions given and that the patient understood all of the instructions, the provider has made himself vulnerable if the patient has any type of misadventure.

Records are scrutinized by multiple entities. Providers and facilities are being challenged to put their best foot forward in many ways. The only evidence the providers have of their veracity and the quality of care provided is the medical record.

Another reason for a quality assessment review of the clinical documentation is the number of requests for medical documentation from contractors paid by CMS for Hierarchical Condition Category (HCC) and HEDIS Health care Effectiveness Data and Information Set, (HEDIS) studies.

These programs are abstracting data from the medical records for calculating risk adjustments based on the severity of diseases.

> *"The ultimate purpose of the CMS-HCC model is to promote fair payments to Medicare Advantage, (MA) plans that reward efficiency and encourage high quality care for the chronically ill.*
>
> *Its use is intended to redirect money away from MA plans that disproportionately enroll the healthy, while providing the MA plans that care for the sickest patients the resources to do so."*
>
> *"Evaluation of the CMS-HCC Risk Adjustment Model." Publication date is March 2011."*

Requests for medical records come from many sources, for different reasons other than reimbursement. For example:

- CMS Contractors, HCC, HEDIS
- Patients
- Attorneys
- Other Providers
- Workers' compensation
- Payers for precertification
- Pre-employment applications
- Military application
- SSI applications

Incomplete, cloned, or deficient records, regardless of the type of deficiency or errors may be evidence of non-compliance, and are a very poor representation of the clinician or the facility. The goal for the CDS is to work with the facilities, clinicians, and staff in the entire documentation process to facilitate "excellence" and "compliance" in the documentation of all medical records entries.

The goal for CDI is the same for all providers/facilities; the challenges may vary based on the provider/facility type.

- **Inpatient hospital:** An example of a challenge in the inpatient hospital setting is monitoring documentation for multiple providers involved in patient care. Maintaining consistent and quality documentation can be difficult because deficiencies may not be identified until after the provider has left the facility.
- **Outpatient hospital** or other outpatient facility plan of care
- **Outpatient Diagnostic Centers:** An example of a challenge in outpatient diagnostic centers is medical necessity to support orders. Often physicians order tests, but it is not clear why. This causes a problem in lack of coverage of the services and utilization of services that may not be medically necessary.
- **Comprehensive Outpatient Rehabilitation Centers:** An example of a challenge in this setting is the accuracy of the patient care plan and the updating of the care plan required every 90 days for Medicare patients
- **Nursing Home Facilities:** An example of a challenge in this type of facility is the proper reimbursement for services performed by other providers when the patient is in a nursing home. The nursing home is responsible for coordinating care for patients admitted to their care.
- **Home Health Care Entities:** An example of a challenge for home health agencies is obtaining a compliant plan of care from the ordering provider. Without it, services are not justified.

The "Least Expected"

The basic guidelines for documentation of E/M services are the "Least Expected." Quality is going above and beyond the basic information. Many times, providers and coders will document the basic information to complete the task at hand. It is difficult to jump through the hoops of state and federal guidelines in all aspects, and also consider specific payer rules, while remaining focused on quality patient care. The burden of documentation is real to all providers and billing staff.

The basic guidelines published by the Centers for Medicare & Medicaid Services (CMS) are relatively tame. Although the documentation guidelines are geared toward E/M services, following them ensures complete documentation for all services provided during an encounter (e.g., diagnostic tests). These general principles help to ensure medical record documentation for E/M services is appropriate:

- The medical record should be complete and legible.
- The documentation of each patient encounter should include:
  - the reason for the encounter and relevant history, physical examination findings, and prior diagnostic test results;
  - assessment, clinical impression, or diagnosis;

- medical plan of care; and
- date and legible identity of the observer.

When ordering diagnostic or other ancillary services, *the rationale for ordering should be easily inferred, if it is not specifically documented*.

- The past and present diagnoses should be accessible to the treating and/or consulting physician.
- All appropriate health risk factors should be clearly identified in the record and the patient's progress and response to treatment, or changes in treatment, should be clear.
- Every record should support the charges submitted on the claim form or patient statement.
- The medical record should be:
  - Complete
  - Precise
  - Reliable
  - Consistent
  - Legible (as stated above)
  - Timely

A host of other guidelines must be reviewed to appropriately document the medical record. Many are specialty-specific or facility-specific. When documentation requirements are identified, policies must be created to maintain and monitor the requirements.

Below are specifics for documentation as published by the Department of Health & Human Services (HHS):

> c. Documentation. Timely, accurate and complete documentation is important to clinical patient care. This same documentation serves a second function when a bill is submitted for payment, namely, as verification that the bill is accurate as submitted. Therefore, one of the most important physician practice compliance issues is the appropriate documentation of diagnosis and treatment. Physician documentation is necessary to determine the appropriate medical treatment for the patient and is the basis for coding and billing determinations. Thorough and accurate documentation also helps to ensure accurate recording and timely transmission of information.
>
> i. Medical Record Documentation. In addition to facilitating high quality patient care, a properly documented medical record verifies and documents precisely what services were actually provided. The medical record may be used to validate:
>
> (a) The site of the service;
>
> (b) The appropriateness of the services provided;
>
> (c) The accuracy of the billing; and
>
> (d) The identity of the caregiver (service provider).

Examples of internal documentation guidelines a practice might use to ensure accurate medical record documentation include the following:

- The medical record is complete and legible;
- The documentation of each patient encounter includes the reason for the encounter; any relevant history; physical examination findings; prior diagnostic test results; assessment, clinical impression, or diagnosis; plan of care; and date and legible identity of the observer;
- If not documented, the rationale for ordering diagnostic and other ancillary services can be easily inferred by an independent reviewer or third party who has appropriate medical training;
- CPT® and ICD-9-CM codes used for claims submission are supported by documentation and the medical record; and
- Appropriate health risk factors are identified. The patient's progress, his or her response to, and any changes in, treatment, and any revision in diagnosis are documented.

For additional information on proper documentation, physician practices should also reference the *Documentation Guidelines for Evaluation and Management Services*, published by Centers for Medicare and Medicaid Services (formerly, HCFA). Currently, physicians may document based on the 1995 or 1997 E/M Guidelines, whichever is most advantageous to the physician.

The CPT® and ICD–9–CM codes reported on the health insurance claims form should be supported by documentation in the medical record and the medical chart should contain all necessary information. Additionally, CMS and the local carriers should be able to determine the person who provided the services. These issues can be the root of investigations of inappropriate or erroneous conduct, and have been identified by CMS and the OIG as a leading cause of improper payments.

*HCFA Reports Clearance Officer, HCFA, Office of Information Services, Security and Standards Group, Division of HCFA Enterprise Standards. Federal Register/V*ol. 65, No. 194/Thursday, October 5, 2000/Notices

The Patient Centered Medical Record

"The OIG acknowledges that patient care is, and should be, the first priority of a physician practice. However, a practice's focus on patient care can be enhanced by the adoption of a voluntary compliance program. For example, the increased accuracy of documentation that may result from a compliance program will actually assist in enhancing patient care."

Office of Inspector General's Compliance Program Guidance for Individual and Small Group Physician Practices Federal Register/Vol. 65, No. 194/Thursday, October 5, 2000/Notices Page 59435

Medical record documentation should be patient centered. The basic premise of medical record documentation is to promote the highest standard of continuity of care.

We must:

- Improve the communication and the dissemination of information between and across all providers of services.
- Provide the appropriate treatment, intervention, and plan of care.
- Improve goal setting and evaluation of care outcomes.
- Improve early detection of problems and changes in health status; and
- Provide "EVIDENCE" of excellent patient care.

The Accuracy and Timing of Documentation

The clinical documentation in a patient's record forms the basis for current and future care of the patient by health care provider(s). The documentation in the record will be the basis from which all providers involved in the patient's care make their decisions concerning the plan of care.

The best way to achieve the most accurate, detailed documentation is for the provider to document the encounter/services as soon as possible after (if not during) the encounter. Providers have many documentation tools at their disposal.

- Speech recognition dictation intergraded into the EMR
- Pre-populated templates designed to assist with specialty specific diagnoses
- Hard copy forms the patient completes describing their condition, problems, injury, and a multitude of other information
- Macros
- Standard acronyms
- Support staff contributing to the record

Even with technology and support staff, clinical documentation continues to be the greatest risk factor for providers and facilities today.

Critical decisions are made based on these records. This includes everything from the most precise information (such as test results, procedure reports, etc.) to subjective information from clinicians. This fact remains constant for every provider and every facility, regardless of site of service.

Part of the "management" of the patient's care is the thorough communication of all pertinent facts concerning the episode of care. This is applicable to inpatient and outpatient services alike. In the facility setting the continued, ongoing documentation of the progress of the patient's condition is critical in providing quality of care. Each progression in treatment is dependent upon the quality of the previously charted note.

Evidence of care is a key factor in clinical documentation. This point takes us back to one of the basic principles of documentation. As stated above: *If it is not documented, it hasn't been done.*

The provider's documentation is the "evidence of care." Records should include:

- A detailed account of the clinician's assessment of the patient and the care planned and provided.
- All relevant information regarding the patient's condition at the encounter.
- The interventions and actions taken to achieve identified health outcomes.
- The patient's response to treatment.
- Potential health risks.
- Evidence the clinician met his or her obligation of care.
- The patient's outcome of care and safety was not compromised in any way by the care provided or omitted in the course of treatment.
- All communication with other relevant clinicians regarding the patient's condition and services rendered.

If there are any changes in the diagnoses as the result of diagnostic tests, these should be documented.

CMS is clear what it considers to be the appropriate timeframe for the documentation to take place to maintain an

accurate medical record. As stated above, "The medical record should be documented during the encounter or as soon as possible following the encounter."

Many providers allow too much time to lapse between the encounter and the documentation process. This holds true for the electronic medical record, as well.

Abbreviations

Abbreviations that are obscure, poorly defined, open to broad interpretation, or have multiple meanings can lead to confusion and errors in patient care. Abbreviations should only be used where they are approved and defined by an organizational policy.

For example, if a provider writes "HTN" when a patient has benign hypertension, there should be a protocol written for the office personnel stating, "When 'HTN' is written in the patient's chart, or on a fee ticket, it is to be coded as benign hypertension, unless otherwise specified." If no protocol exists, and "HTN" is documented, the appropriate way to code "HTN" would be hypertension, unspecified.

Another common problematic diagnosis is "urosepsis." Does the provider truly mean infection confined to the urinary system and not in the blood? Has the bacteria in the urine progressed to septicemia or sepsis? The protocol should state that, unless otherwise documented, the term "urosepsis" is infection in the urinary system only. Each time a coder sees this diagnosis he or she will report urosepsis. There will be no need to query the provider if the bacteria have progressed to septicemia or sepsis.

Another example is the abbreviation "I&D." Does the provider mean irrigation and debridement, or irrigation and drainage? This is another example where protocols and provider/staff communication can eliminate many problems and improve efficiency.

Internal protocols are highly effective in resolving documentation issues when problematic documentation is presented.

It is much better to add "quality" and "detail" to assist in the coding accuracy. The provider can document benign hypertension, state irrigation and debridement, and clearly demonstrate in the record the patient has septicemia or has sepsis due to a urinary infection.

The Joint Commission (JC) is a not-for-profit independent organization that accredits health care facilities (e.g., hospitals). Accreditation by the JC signifies quality. For a facility to achieve and maintain JC accreditation, it must comply with the requirements and regulations identified by the JC. For example, the JC now requires the term "unit" be specified. "U" or "u" should not be used for unit. The provider must document, for example, "5 units." This can be a common problem in the hospital setting. This type of compliance measure should carry over in the office setting.

We must listen to our providers; they can teach us a great deal. Providers love to teach. It is our responsibility to work alongside of them, to assist them with the burden of documentation required by the industry, and to work hand in hand with them to facilitate quality improvement. Developing effective lines of communication is one of the most critical aspects of any improvement process. We must develop a protocol that will accommodate the documentation improvement process and encourage and enable our providers to facilitate change.

Diagnostic Data

Diagnostic data for services rendered does not change. Code selection may vary based on the place of service or provider type. The clinical documentation in the record will not differ from setting to setting. The clinical condition of the patient does not change, only the diagnoses reported. For example, according to the ICD-9-CM Official Coding Guidelines, if the services are performed in the outpatient office setting, the signs and symptoms are reported until a definitive diagnosis is determined; however, in the inpatient setting, the diagnoses for the suspected condition is reported.

Financial Impact

A significant effect of incomplete documentation in a patient's medical record is loss in revenue. The inaccuracy of medical documentation is a clear indicator to the CDS that payments may be inaccurate.

Incomplete documentation can lead to undercoding or overcoding a service. For example, the patient presents for a follow-up visit for otitis media. The documentation generated using the EMR supports a 99214; however, the medical necessity of the service may only warrant a 99212 or 99213, depending on the treatment. If the service were coded based on the volume of documentation rather than the medical necessity of services rendered, it would lead to an overpayment of the encounter.

In CPT® certain procedures are described as simple or complicated (e.g., 10060 *Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutane-*

ous abscess, cyst, furuncle, or paronychia); simple or single and 10061 *Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); complicated or multiple*). If the provider performs a complicated incision and drainage but fails to include in the documentation the work that made it complicated, the only option is to report the simple procedure—which leads to a loss in revenue because the complicated procedure has higher reimbursement.

Legal Protection

The details in a well-documented note are a provider's best defense in any legal situation. If the record is deficient in details, there is no "evidence" to support a provider's testimony. "Evidence" of procedures and care provided—or not provided or documented—is just as important in the "legal" aspect as it is in the billing and patient care.

Chapter 3:

The Electronic Medical Record

Electronic medical record (EMR) and electronic health record (EHR) offer many advantages to the physician's practice. These include an easier and more user-friendly sharing of patient information among health care providers, immediate access to patient information, and accelerated transmission of claims. EMRs may also decrease staff requirements for transcribing, verifying, entering, and storing data. Using EMR templates in documentation can often enhance the speed and efficiency of documentation, making documentation more legible and reducing errors. For these and other reasons, providers are increasingly moving toward EMR and EHR.

The use of templates does have many advantages. When documentation is done correctly, the use of templates saves time and money. When the record is documented for the current service and on the same date as the encounter, accuracy increases. The electronic record allows for better communication and coordination of care and eases the burden of manual documentation. The records are legible and more comprehensive than hand-written notes. The cost of transcription is eliminated, or at least decreased.

Pitfalls in the Use of Electronic Medical Records

EMRs are effective tools if used correctly. The purpose is to provide complete and comprehensive data. When EMRs are used to produce a large volume of documentation instead of quality and relevant documentation, it defeats the purpose. This is not only bad for patient care, but also a huge compliance risk. CDS help providers to document appropriately using the EMR for the practice/facility.

The copy and paste, or "cloning," of the medical records is on the OIG Work Plan for 2012. A great deal of scrutiny is being placed on repetition. Some payers state that records deficient in "unique" patient data and current, applicable information associated with the current date of service will result in claims denied for lack of medical necessity.

The record must be detailed enough to provide comprehensive clinical data to facilitate continuity of care, and it should be concise and pertinent to the current encounter.

A cloned note causes problems for providers. Everything looks the same; thus, many physicians are opposed to the use of EMRs. They receive notes from their colleagues using EMR templates that contain pages of useless information, or "fluff." Physicians may have to scan many "unnecessary" pages before they can find something unique to their patient. For example, a complete past, family and social history is not required for every patient encounter. Often, this information is carried over from a previous visit and it has no relevance for the patient's presenting problem.

Many EMR-generated notes are too lengthy and contain much more information than needed. The only time previously populated data should be brought forward is when the information is pertinent to the current encounter. CMS has posted several notices educating providers about the inappropriateness of copying over a previously documented comprehensive Review of Systems (ROS) in a follow-up encounter. It is not medically necessary to document a comprehensive history on the same patient seen two or three weeks prior.

Unfortunately what some EMRs offer is the copy over of all previous history data, or of none. When submitting a hard copy of the medical record for an established patient encounter for a follow-up visit, an interim history and ROS is often all that is needed. The clinicians should docu-

ment the interim history that is appropriate for the current encounter. Controls can be put in place to manage this. Controls are going to be dependent upon the functions of the EMR and the documentation policies identified by the practice/facility.

Templates to document the encounters are used over and over, and state the same thing. Patient's improvement, response to treatments, and current conditions are lost in the maze of electronic "point and clicks." The integrity of documentation of the patient's condition and services rendered is lost. The CDS can assure the integrity of the EMR. This is a critical area of oversight and maintenance for the CDS. The template development and daily use must be continuously reviewed and updated, when needed. Providers who are not complying with the internal policies set by the CDS and/or compliance officer must be dealt with swiftly to prevent the entire group/facility from being at risk.

The OIG has listed in the 2012 work plan the focus on EMR for cloning.

Evaluation and Management Services: Potentially Inappropriate Payments

We will assess the extent to which CMS made potentially inappropriate payments for E/M services and the consistency of E/M medical review determinations. We will also review multiple E/M services for the same providers and beneficiaries to identify electronic health records (EHR) documentation practices associated with potentially improper payments. ***Medicare contractors have noted an increased frequency of medical records with identical documentation across services.*** Medicare requires providers to select the code for the service based upon the content of the service and have documentation to support the level of service reported.

(CMS' Medicare Claims Processing Manual, Pub. No. 100-04, ch. 12, § 30.6.1.) (OEI; 04-10-00181; 04-10-00182; expected issue date: FY 2013; work in progress) 2012 OIG Work Plan Publication October 2011

Authentication of Author

An EHR or EMR must have the capability to allow more than one provider/caregiver to enter or delete information from each entry into the system. Without this capability, all information entered will be attributed to the specific provider. Very often, another staff member or nurse will initiate a chart or note, providing information such as patient vital signs, chief complaint, date of injury, etc. If the electronic record does not have the capability to save and display the author and date of each entry, all information entered is attributed to services rendered by the provider.

In addition, unlicensed personnel may be allowed to provide services that are in turn entered and submitted as being rendered by the provider. Ancillary staff members may enter the chief complaint or reason for the encounter, the injury date, ROS, allergies, and PFS history components. The provider's responsibility is to review thata, acknowledge the information, and expound on pertinent positive or negative findings. If, for example, a physician assistant enters data into a record based on the services rendered, his or her signature must be included in the record. The physician must counter sign the record. If the provider provides a portion of the service and documents, he or she also must sign the record**.**

Integrity of Patient Data

Electronic records may allow certain information, such as patient demographics, insurance information, place of service, and more to automatically populate using a system "default." Turn off certain "defaults" to ensure accountability for data entry. Medical records and practice management systems that interface with one another normally have a mechanism in place for tracking the data entry to identify the individual keying and/or changing the data.

Passwords should be secure to maintain the integrity of tracking reports. Many elements of patient and claim data should be keyed at each episode of care. Doing so places accountability for data entry on an individual. Not all patient data should default. Continuously using defaults for patient data makes it very easy for individuals to continue to use the same information and not "update" with each encounter.

There is a fine line between accuracy through automation and maintaining ongoing updates to this critical information. Automation enhances the billing process and other financial transactions performed on behalf of the patient. However, there must be the accountability of the human elements of data entry and data updates. Generating claims with inaccurate information is not only abusive; it can be fraudulent if done "knowingly." If information is not updated, or cannot be updated at the time of check in, the claims should be suspended and "held" until the data is updated.

Electronic records also make it easier and more tempting for individuals to steal patient identities and submit fraudulent claims for profit, or use the information for other fraudulent activities. Best practice guidelines for password security, data entry tracking, and default set ups should always be maintained and monitored.

Computer Assisted Coding

Computer Assisted Coding (CAC) is a tool used in tandem with EMR for electronic coding based on the elements checked or populated by the provider in the EMR. If documentation is not sufficient, this tool will assign a lower level code even though the medical necessity of the encounter is actually much higher. CAC is not always the best tool for the providers. Providers are able to code based on 1995 or 1997 documentation guidelines. There are times the 1995 guidelines are better suited for the case. The computer does not have the capability to assign a code based on subjectivity. The CDS should make sure the "system" does not assign a code that was too high or too low for the encounter based on medical necessity and documentation to support the service.

Signature Requirements

Another significant factor in determining medical necessity is the signature of the rendering provider, the co-signature of the supervising provider services are billed "incident-to" the provider services, and signatures of the ordering provider. Signature requirements are well-published.

If signature requirements are not met, the claim can be denied for medical necessity. For medical review purposes, Medicare requires services provided/ordered be authenticated by the author. The method used must be a handwritten or an electronic signature. Stamp signatures are not acceptable.

There are some exceptions. For example, orders for clinical diagnostic tests are not required to be signed. The rules in 42 CFR 410 and the Medicare Benefit Policy Manual, chapter 15, section 80.6.1, state that if the order for the clinical diagnostic test is unsigned, there must be medical documentation by the treating physician (e.g., a progress note) that he or she intended the clinical diagnostic test be performed. The intent of the test being performed must be documented and authenticated by the author via a handwritten or electronic signature. The entire text for signature requirements can be found at the following link. www.cms.gov/MLNMattersArticles/downloads/mm6698.pdf. The chart demonstrating the acceptable types of signatures can be found in Appendix A. Other signature requirements may exist for other payers and by state law. The information in this chapter is specific to CMS.

Examples of Acceptable Signatures:

- Legible full signature
- Legible first initial and last name
- Illegible signature over a typed or printed name
- Illegible signature where the letterhead, addressograph, or other information on the page indicates the identity of the signature.
  - Example: An illegible signature appears on a prescription. The letterhead of the prescription lists three physicians' names. One of the names is circled.
- Illegible signature NOT over a typed/printed name and NOT on letterhead, but the submitted documentation **is accompanied by** a signature log, or an attestation statement
- Initials over a typed or printed name
- Initials NOT over a typed/printed name but **accompanied by** a signature log, or an attestation statement
- Unsigned handwritten note where other entries on the same page in the same handwriting are signed.

Examples of unacceptable signatures:

- Illegible signature NOT over a typed/printed name, NOT on letterhead and the documentation is **unaccompanied** by a signature log, or an attestation statement
- Initials NOT over a typed/printed name **unaccompanied** by a signature log, or an attestation statement
- Unsigned typed note with provider's typed name; example: John Whigg, MD
- Unsigned typed note without provider's typed/printed name
- Unsigned handwritten note, the only entry on the page
- "Signature on file"

Providers should not add late signatures to the medical record (beyond the short delay that occurs during the transcription process), but should make use of the signature authentication process.

Patient Confidentiality

The EMR has made it easier for unauthorized individuals to view a patient's record if the appropriate systems and

controls are not put in place. HIPAA mandates that all patient data be stored, transmitted, and accessed by only those who have permission to access, or those directly involved with the treatment, processing, and payment of health care claims.

Systems should be locked and inaccessible to all other individuals. Individuals in the medical office who have no involvement with these aspects should be prohibited from accessing the patient medical record. Staff should be well trained on HIPAA privacy laws. Automation presents a higher risk for the transfer of incorrect patient information and great care must be taken to ensure all transactions are appropriate.

Chapter 4:

Mastering the Documentation Process

- Know the required documentation for the service rendered
- Perform the documentation as soon as possible after the service
- Develop tools to assist with consistency
- Follow up with auditing
- Educate providers and staff

The accuracy of the documentation in the medical record is equally as important as its completeness. Accuracy assists in providing patients with optimal medical care based on details provided in their medical records.

Another reason for ensuring accuracy in the medical record is to provide governmental agencies and any other entity accessing the patient's medical record with accurate and complete information. One way to ensure an audit is to send your patient record for review with a record that demonstrates a trend of inaccuracies. These can be as simple as:

- Sloppy text
- Misspelled words
- Phrases that do not make sense
- Dictation that is not complete
- Skips in the text that indicate the words were not understood
- Incomplete sentences
- Evidence of cloning or copying data from previous dates of service that is not relevant to the current service
- Incorrect dates of service
- Missing dates of service
- Missing dosage and strength of medication ordered

These are only a few examples that are common errors in documentation. ***It should be assumed that any and all clinical documentation will be scrutinized at some point.***

With improved documentation, collections improve. If diagnoses are reported in the medical record and are not reported on the claim form, this can result in denied claims. Accuracy of documentation ensures the claims go out correctly the first time, and the need to re-bill corrected claims and/or appeal claims held for additional information is minimized.

The documentation justifies the reason for the medical care provided. The medical necessity must be clearly indicated for all services rendered and for diagnostic or other ancillary services ordered. Improved documentation (for example, which medications are prescribed and which diagnostic tests have been ordered) assists the staff and other providers with the information they need to perform their duties, regardless of their department or area of care.

The OIG states an ongoing chart evaluation process is critical to a successful compliance program. This is one of the many reasons for clinical documentation improvement. The only way to know if the documentation is deficient is have internal policies to monitor the documentation. Developing a systematic process of review, identification, correction, and provider education is required to maintain consistent quality documentation. A formal review with a report of findings has a greater impact than communication to the provider on a case-by-case basis. The objective is to identify and remedy the deficiencies, eliminating the number of "case by case" queries.

The extent and frequency of chart audits will vary based on the size of the practice. Every practice should have a mechanism in place for routine periodic chart review. The more reviews performed over time, the less likely major problems will present. Documentation improvement is an ongoing process and becomes more manageable with each step.

The OIG offers a baseline for implementing a compliance plan for physician practices by providing seven steps for providers to use as a guide.

The Seven Basic Components of a Voluntary Compliance Program

The OIG believes that a basic framework for any voluntary compliance program begins with a review of the seven basic components of an effective compliance program. A review of these components provides physician practices with an overview of the scope of a fully developed and implemented compliance program. The following list of components, as set forth in previous OIG compliance program guidance, can form the basis of a voluntary compliance program for a physician practice:

1) Conducting internal monitoring and auditing through the performance of periodic audits;

2) Implementing compliance and practice standards through the development of written standards and procedures;

3) Designating a compliance officer or contact(s) to monitor compliance efforts and enforce practice standards;

4) Conducting appropriate training and education on practice standards and procedures;

5) Responding appropriately to detected violations through the investigation of allegations and the disclosure of incidents to appropriate government entities;

6) Developing open lines of communication, such as (1) discussions at staff meetings regarding how to avoid erroneous or fraudulent conduct and (2) community bulletin boards, to keep practice employees updated regarding compliance activities; and

7) Enforcing disciplinary standards through well-publicized guidelines.

These seven components provide a solid basis upon which a physician practice can create a compliance program.

Office of Inspector General's Compliance Program Guidance for Individual and Small Group Physician Practices Federal Register/Vol. 65, No. 194/Thursday, October 5, 2000/Notices 59435

Other policies and procedures may be appropriate for the overall compliance process. By ensuring ethical business practices through compliance programs, health care providers reduce their risk of criminal and civil litigation.

Because our focus for this workshop is documentation improvement, we are limiting our discussion to that aspect of the auditing process. There are parallels associated with an overall compliance plan and the clinical documentation improvement process.

Internal protocols and policies should cover topics such as provider queries. The queries can be tracked by provider, to demonstrate the documentation areas each provider needs assistance with. Many EMRs have the functionality to allow for the creation of documents within the program that can be emailed to, or put in a task file for, a provider. This form can be dated and timed, and tracked by the system. The EMR can be updated to make the documentation more concise based on the frequency and subject of the queries. The process should be tracked to identify the timeliness of the provider's response.

Policies should be put in place as to how many queries a provider is allowed before he or she receives education. There needs to be a protocol as to where the queries will be stored. The response from a provider concerning medical care, diagnoses, and/or procedures performed should be kept for evidence of care. The chart record may need an addendum.

Another protocol to establish is when to release charges, or how long to hold or suspend a claim because of errors or incomplete information. Coders should have specific direction as to how long to hold a claim. If the claim is being held for feedback from the provider because of deficient documentation or questions concerning the claim, there should be policies to accommodate this process. Another effective policy is to determine who will initiate queries and who will follow-up to make sure the claim is not "lost in the shuffle." These concerns must be tailored to each practice based on size and need.

Policies should be developed concerning typographical errors in transcription and the overutilization of EMR templates and pre-populated data. This task should be assigned to an individual who will monitor such use. A timeframe should be established for making corrections.

Policies for corrections of handwritten notes and policies concerning addendums must be systematically in place to facilitate the process of documentation improvement, producing clarity and accuracy.

Protocols for documentation are needed to establish policies for the practice's use of abbreviations. Abbreviations and symbols can be an effective and efficient form of documentation if their meaning is well understood by the health provider who is using and/or reading them. Abbreviations should have clear definitions and be used practice wide for consistency in documenting and abstracting.

Medical Necessity

Medical necessity should be the driving factor for all services provided to a patient. There are many sources that review the importance of medical necessity.

Title XVIII of the Social Security Act, section 1862(a) (1) (A).

Medicare (CMS) defines "medical necessity" as services or items reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. While that sounds like a hard and fast rule, consider that CMS—and any payer, for that matter—has the power under the Social Security Act to determine if the method of treating a patient is reasonable and necessary on a *case-by-case basis.*

Even if a service is reasonable and necessary, coverage may be limited if the service is provided more frequently than allowed under a National Coverage Policy, or a Local Coverage Determination policy. These policies mandate indications and limitations of coverage, documentation requirements, and diagnostic conditions; and reporting documentation guidelines are published by CMS in all National Coverage Determinations. ***Any service that is not appropriately documented can be denied for medical necessity.***

"Medical Necessity is the overarching criterion for code selection."

The Recovery Audit Contractors (RAC) demonstration project in 2008 revealed an astounding 70 percent error rate based solely on medical necessity: 40 percent of claims reviewed resulted in an overpayment and 70 percent of those representing an overpayment were due to medical necessity, or the lack thereof. Medical necessity drives:

- Code selection
- Services performed
- Procedures and services ordered

When coding evaluation and management services, we are bound to the severity of the presenting problem, not the quantity of documentation. Documentation plays a role, but code selection is driven by the nature of the presenting problem.

Not only can medical necessity issues result in claim denials, they can also constitute fraud and/or abusive billing charges. For example:

(1) A New York opthalmologist paid an $8.5 million settlement for performing medically unnecessary, contraindicated and un-performed services. The settlement agreement provided the doctor would be ***permanently excluded from all federally- funded health care programs***. This physician's own medical charts did not justify the wide scope of services for which he submitted bills. He also created and submitted new documentation, sometimes years after the questioned dates of service, to attempt to justify his claims after Medicare requested supporting documentation.

(2) A California hospital agreed to pay ***a $1.3 million settlement*** to resolve a qui tam case involving fraudulent Medicare billings for magnetic resonance imaging (MRI) and neurological diagnostic tests. The tests had been performed on patients who responded to advertisements by a hospital neurologist. The neurologist would diagnose every patient with the same disorder, radiculopathy, which required the patient to receive a battery of tests from the hospital. The neurologist would perform the tests himself, but would do so after normal business hours and without other physicians present. The neurologist billed Medicare for far more tests than could normally be done in the amount of time.

(3) In Mississippi, a hospital chain agreed to pay a $1.5 million settlement in a qui-tam lawsuit, in which it was alleged that the hospital billed under the physician provider numbers when, in fact, the services were rendered by nurses. The hospital billed under the physician provider ID to achieve higher rate of reimbursement rate.

These are three examples of the millions of dollars paid in fines and penalties for medical necessity issues. These represent deliberate acts of fraud and abuse; however, many cases are brought against providers because of documentation issues, (e.g., poor documentation lacking in quality and accuracy of information). Adding to this mix are the increasing regulations and mandates that providers struggle with. "Copy and paste" issues, cloned records, and documentation by ancillary staff members contribute to unintentional "abusive" billing.

Providers are at the mercy of their willingness to change and to be compliant with the mandates of the medical industry. Providers who fail to document records appropriately, or those clinicians who are always late with their documentation, are putting themselves at high risk of non-compliant

documentation and abusive billing practices. The CDS can play a key role in assisting the providers with the tools and information they need to embrace the changes and comply with requirements.

The CDS is at times a liaison between coding professionals and providers. The team work provides higher levels of accuracy and training. Had the services of a CDS and coding professionals been used in the above examples, the issues stated might not have happened. The CDS oversees and ensures that the services are performed, and the documentation of services is:

- Complete
- Accurate
- Medically necessary
- Appropriate for the patient and place of service
- Billed under the provider who performed the service

Unfortunately, we see that in cases of true fraud, the providers will not employ specialist and/or professionals who will ensure all documentation, billing, and reporting of services are appropriate.

Authoritative Resources

Try to provide concise, authoritative information. There are many resources available that may be referenced. For example, CMS, the AMA, AAPC, and specialty societies, just to name a few. ICD-9-CM official guidelines are published to assist CDS in supporting their work for ICD-9 coding and reporting. The AMA offers coding guidelines and education for CPT® coding. Private payers such as BCBS, United Healthcare, and Aetna publish their own "medical policies" for specific procedures, services, and supplies. The amount of authoritative information and resources is almost overwhelming. Below are a few of the multiple links to access information to support training, and assist with creating policies, procedures and, documentation improvement efforts.

www.cms.gov

www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/EMDOC.html

www.aapc.com/provider-manual/

http://oig.hhs.gov/

www.jointcommission.org/

www.novitas-solutions.com/index.html

www.gpo.gov/fdsys/browse/collection.action?collectionCode=FR

www.cms.hhs.gov/Regulations-and-Guidance/Manuals/Internet-Only-Manuals-IOMs.html

www.jcrinc.com/

Hospitals may have their own internal policies concerning compliance with documentation and quality assurance.

The Joint Commission is an independent, not-for-profit organization that accredits and certifies health care organizations.

The Joint Commission requires specific guidelines and standards for ASCs, Hospitals, Long-term Care Facilities, Critical Access Hospitals, and many other health care facilities.

Even though The Joint Commission is a private organization, it has established itself nationwide as an organization promoting the highest quality of health care. Being accredited by this organization is evidence that the facility has met high operational standards and is committed to quality of care in a safe environment.

The Joint Commission establishes guidelines and requirements for accreditation. Clinical documentation in all areas in the hospitals and facilities is reviewed for compliance to the standards established by the Joint Commission.

Accreditation by the Joint Commission is evidence of "quality and excellence" within the health care community. The CDS must be aware of the standards and guidelines they require. This is one more reason for the increasing demand for professionals highly skilled in documentation oversight and compliance.

One of the most authoritative resources is the Code of Federal Regulation, (CFR) Title 42: Public Health Section 410.

http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=cf0dac0980199298a0d291486f42125&rgn=div5&view=text&node=42:2.0.1.2.10&idno=42

This resource offers a wealth of information on the statues the federal government imposes for Supplemental Medical Insurance Benefits. Information is organized in a user-friendly format.

Below is an excerpt of the table of contents:

Subpart A—General Provisions

- Subpart B-Medical and Public Health Services.
- Subpart C-Home Health Services under SMI
- Subpart D-Comprehensive Outpatient Rehabilitation Facility (CORF)
- Subpart E-Community Mental Health Services. Providing Partial Hospitalization services.
- Subpart F-Reserved
- Subpart G-Medical Nutrition Therapy
- Subpart H-Outpatient Diabetes Self-Management Training and Outcome Measures
- Subpart I-Payment of Benefits

For example, Subpart B is "Medical and Health Services." This contains § 410.10-§ 410.78. There are 78 topics concerning health care services within subpart B. Just looking at a few will give you an idea of the information within this resource. Keep in mind these are federal regulations at § 410.20, Physicians' services:

- § 410.21 Limitations on services of a Chiropractor.
- § 410.22 Limitations on services of an optometrist.
- § 410.23 Screening for glaucoma: Conditions for and limitations on coverage.
- § 410.26 Services and supplies incident to a physician's professional services: Conditions.

To further demonstrate the quality and comprehensive information in each section, look at the federal regulations concerning Mammography Services, § 410.34. The medial record documentation must fall within these parameters for compliance and payment.

If the CDS is employed by an Independent Diagnostic Facility, this is one of the many resources he or she should be familiar with. The bolded information is where we see the need for specific documentation.

The documentation must demonstrate:

- The medical necessity for the order for a diagnostic mammogram.
- The signs and symptoms of a breast disease.
- The documentation that there is a personal history of breast cancer or a personal history of a (biopsy-proven) benign breast disease.
- The interpretation of the results of the procedure.
- The clear distinction within the record of the type of mammogram being ordered; if the order is for a screening mammogram, the age of the patient and the date of the last mammogram are important documentation.

The content of section 410.34 is demonstrated below.

§ 410.34 Mammography services: Conditions for and limitations on coverage.

(a) *Definitions.* As used in this section, the following definitions apply:

(1) *Diagnostic mammography* means a radiologic procedure furnished to a man or woman with signs or symptoms of breast disease, or a personal history of breast cancer, or a personal history of biopsy-proven benign breast disease, and includes a physician's interpretation of the results of the procedure.

(2) Screening mammography means a radiologic procedure furnished to a woman without signs or symptoms of breast disease, for the purpose of early detection of breast cancer, and includes a physician's interpretation of the results of the procedure.

(3) *Supplier of diagnostic mammography* means a facility that is certified and responsible for ensuring that all diagnostic mammography services furnished to Medicare beneficiaries meet the conditions for coverage of diagnostic mammography services as specified in paragraph (b) of this section.

(4) *Supplier of screening mammography* means a facility that is certified and responsible for ensuring that all screening mammography services furnished to Medicare beneficiaries meet the conditions and limitations for coverage of screening mammography services as specified in paragraphs (c) and (d) of this section.

(5) *Certificate* means the certificate described in 21 CFR 900.2(b) that may be issued to, or renewed for, a facility that meets the requirements for conducting an examination or procedure involving mammography.

(6) *Provisional certificate* means the provisional certificate described in 21 CFR 900.2(m) that may be issued to a facility to enable the facility to qualify to meet the requirements for conducting an examination or procedure involving mammography.

(7) The term *meets the certification requirements of section 354 of the Public Health Service (PHS) Act* means that to qualify for coverage of its services under the Medicare pro-

gram, a supplier of diagnostic or screening mammography services must meet the following requirements:

(i) Must have a valid provisional certificate, or a valid certificate, that has been issued by FDA indicating that the supplier meets the certification requirements of section 354 of the PHS Act, as implemented by 21 CFR part 900, subpart B.

(ii) Has not been issued a written notification by FDA that states that the supplier must cease conducting mammography examinations because the supplier is not in compliance with certain critical certification requirements of section 354 of the PHS Act, implemented by 21 CFR part 900, subpart B.

(iii) Must not employ for provision of the professional component of mammography services a physician or physicians for whom the facility has received written notification by FDA that the physician (or physicians) is (or are) in violation of the certification requirements set forth in section 354 of the PHS Act, as implemented by 21 CFR 900.12(a)(1)(i).

(b) *Conditions for coverage of diagnostic mammography services.* Medicare Part B pays for diagnostic mammography services if they meet the following conditions:

(1) They are ordered by a doctor of medicine or osteopathy (as defined in section 1861(r)(1) of the Act).

(2) They are furnished by a supplier of diagnostic mammography services that meets the certification requirements of section 354 of the PHS Act, as implemented by 21 CFR part 900, subpart B.

(c) *Conditions for coverage of screening mammography services.* Medicare Part B pays for screening mammography services if they are furnished by a supplier of screening mammography services that meets the certification requirements of section 354 of the PHS Act, as implemented by 21 CFR parts 900, subpart B.

(d) *Limitations on coverage of screening mammography services.* The following limitations apply to coverage of screening mammography services as described in paragraphs (c) and (d) of this section:

(1) The service must be, at a minimum a two-view exposure (that is, a cranio-caudal and a medial lateral oblique view) of each breast.

(2) Payment may not be made for screening mammography performed on a woman under age 35.

(3) Payment may be made for only 1 screening mammography performed on a woman over age 34, but under age 40.

(4) For an asymptomatic woman over 39 years of age, payment may be made for a screening mammography performed after at least 11 months have passed following the month in which the last screening mammography was performed.

This is one of the most authoritative resources available. When reviewing the medical record for compliance, quality, and medical necessity, it is important to look for the federal regulations concerning that topic. The documentation is the evidence the service or procedure is within the parameters of federal requirements.

This resource is one of many available for research and training for clinical documentation improvement. The resources needed are determined by the objective of the CDS at a given episode of review.

There is a wide scope of the responsibilities the CDS may be charged with. Each specialty will bring different nuances to the table. Some of the variables affecting the responsibilities are listed below (the list is not all-inclusive):

- The size of the practice
- The type of facility or entity
- The state of compliance or non compliance of the practice of facility
- The volume and type of payer mix may determine the structure and capacity within which the CDS will work

Educating the Clinicians

The CDS must also be able to train providers on the importance of "detailed" and "quality" documentation. Most providers have an inherent knowledge of what should be documented for clinical standards; however, there is a gap between clinical standards and the coding systems.

To effectively educate the provider, we must first understand the level of respect that is required. The CDS must demonstrate respect for the providers and their situations. He or she must establish integrity and accountability. Coding professionals, auditors, and CDS must earn credibility with those being trained. All professionals responsible for educating providers must do so with current, accurate, and authoritative information. Trainers should never be aggressive, demanding, or insulting. It is impor-

tant that the provider or administrator set the stage and conditions for training whenever possible.

There are times that individuals are required to undergo training as part of compliance measure for a facility or private practice. It is important to understand that clinicians and staff members may be frustrated about having to "waste" their time in training. At times, they may be difficult to work with. Never take unpleasant responses and inappropriate comments personally. As a trainer, it is your responsibility to communicate the information in the most professional manner, to create the most positive and effective results. You have no control over what the trainee decides to do with the information given.

One must understand what the provider responds to best. Some providers simply want to be told what to do. Others want to read every document one can provide to support the instruction and guidance. Some respond well with examples of their own documentation, while others may be offended if you present a document of their own that is deficient in some way as a learning tool.

When training providers, it is best not to use abstracts. Use data that is meaningful and information pertinent to the deficiency. The CDS must focus on data that needs attention and correction. This may involve the process of demonstrating a loss in reimbursement. Demonstrating the risk factors in terms of payment recoupment, prepayment audits, and potential fines and consequences as the result of being non compliant is also effective. Normally, clinicians will respond to at least one of these demonstrations.

Chapter 5:

The Impact of ICD-10 on Clinical Documentation

The ICD-10 implementation date has been postponed. The new implementation date is October 1, 2014. Advocates for the postponement requested more time for preparation and implementation.

ICD-9 versus ICD-10

To identify the impact ICD-10 will have on the documentation process, you must be aware of some of the fundamental differences in the two code sets.

ICD-9-CM	ICD-10-CM
3-5 characters	3-7 characters
13,000 codes	68,000 codes
1st character can be • Numeric • E • V	1st character is • Alpha 2-3 characters • Numeric 4-7 characters • Alpha or • Numeric
Limits space for new codes	Ability to expand
Lacks detail	Add specificity
Lacks laterality	Demonstrates right and left, etc.

Example 1: Carpal Tunnel Syndrome

ICD-9-CM: There is one 4-character code for Carpal Tunnel Syndrome in ICD-9-CM.

√ **4th 354** Mononeuritis of upper limb and Mononeuritis multiplex
354.0 Carpal tunnel syndrome
(Modifiers are used to designate laterality).

ICD-10-CM: Laterality will be incorporated into the diagnosis code.

√ **4th G56** Mononeuropathies of upper limb
√ **5th G56.0** Carpal tunnel syndrome

G56.00 Carpal tunnel syndrome, **unspecified** upper limb

G56.01 Carpal tunnel syndrome, **right** upper limb
G56.02 Carpal tunnel syndrome, **left** upper limb

Combination Codes

The ICD-10-CM also expands on the use of combination codes. Combination codes are single codes that report more in-depth details of a diagnosis. The combination

code eliminates the need for reporting two or three additional codes to report the same details of the condition.

Combination codes are used to report:

- Two diagnoses
- A diagnosis with an associated secondary process
- A diagnosis with an associated complication

We can compare nine codes for pressure ulcers in ICD-9-CM to 125 codes for ICD-10-CM and immediately see the need for detail with the clinical documentation.

Example 2: Pressure ulcer of the ankle

ICD-9-CM: Pressure ulcer **of the ankle**

707.06

ICD-9-CM instructs coders to use an additional code to report the stage of the ulcer.

707.21 Pressure ulcer stage 1

ICD-10-CM: Pressure ulcer **L89**

The first three characters identify the condition of "pressure ulcer" **(L89)**

The fourth character identifies the anatomical site
L89.5 Pressure ulcer of ankle

The Fifth demonstrates laterality (no modifier is needed):

√ 5th

- 0 unspecified ankle
- 2 right ankle
- 3 left ankle

The Sixth character is the designation of the stage of the ulcer.

√ 6th

- 0 unstageable
- 1 Stage 1
- 2 Stage 2
- 3 Stage 3
- 4 Stage 4
- 9 Unspecified stage

There are 18 codes to select from:

√ 6th L89.50 Pressure ulcer **of unspecified ankle**

L89.500 Pressure ulcer of unspecified ankle, unstageable

L89.501 Pressure ulcer of unspecified ankle, stage 1

L89.502 Pressure ulcer of unspecified ankle, stage 2

L89.503 Pressure ulcer of unspecified ankle, stage 3

L89.504 Pressure ulcer of unspecified ankle, stage 4

L89.509 Pressure ulcer of unspecified ankle, unspecified stage

√6th L89.51 Pressure ulcer **of right ankle**

L89.510 Pressure ulcer of right ankle, unstageable

L89.511 Pressure ulcer of right ankle, stage 1

L89.512 Pressure ulcer of right ankle, stage 2

L89.513 Pressure ulcer of right ankle, stage 3

L89.514 Pressure ulcer of right ankle, stage 4

L89.519 Pressure ulcer of right ankle, unspecified stage

√6th L89.52 Pressure ulcer **of left ankle**

L89.520 Pressure ulcer of left ankle, unstageable

L89.521 Pressure ulcer of left ankle, stage 1

L89.522 Pressure ulcer of left ankle, stage 2

L89.523 Pressure ulcer of left ankle, stage 3

L89.524 Pressure ulcer of left ankle, stage 4

L89.529 Pressure ulcer of left ankle, unspecified stage

Looking at the specificity of these descriptions, you can see how important it will be for the physician to document additional information that he or she may not be accustomed to. In addition, it will require the coder to have a better understanding of anatomy and physiology, terminology, and disease processes to accurately code the diagnosis.

Potential Categories at Risk for Insufficient Documentation ICD-10-CM

Providers will need education and identification of these categories so that they can provide sufficient documentation for coding to the highest level of specificity.

The areas with some of the changes are:

Diabetes Mellitus (DM)

Significant additions to ICD-10-CM are the codes added to report diabetes mellitus. There are more than 200 codes

for DM in ICD-10-CM. This is an example of the detail provided within ICD-10-CM.

Diabetes mellitus codes in ICD-10-CM are combination codes that include:

- Type of diabetes mellitus
- Body system affected
- Complications of that body system

There are five diabetes mellitus categories in ICD-10-CM used to demonstrate the "type" of diabetes. These are three digit category codes.

- E08 due to an underlying condition
- E09 Drug or chemical induced
- E10 Type I DM
- E11 Type 2 DM
- E13 Other specified DM

All of the categories above (with the exception of E10, Type I DM) include a note directing users to use an additional code to identify any insulin use (Z79.7).

To illustrate the arrangement of the codes, we will look at the E11 category. We first see instructions indicating the codes excluded from this category. The "exclude" instructions have the same meaning in ICD-10 as in ICD-9

E11. Type 2 diabetes

Excludes:

- DM due to underlying condition (E08.-)
- drug or chemical induced DM (E09.-)
- gestational diabetes (O24.4-)
- neonatal DM (P70.2)
- post pancreatectomy DM (E13.-)
- post-procedural DM (E13.-)
- secondary DM NEC (E13.-)
- type 1 DM (E10.-)

E11**.0 Type 2 diabetes mellitus with hyperosmolarity**

E11.0**0** Type 2 diabetes mellitus with hyperosmolarity **without** nonketotic hyperglycemic-hyperosmolarity **coma** (NKHHC)

E11.0**1** Type 2 diabetes mellitus with hyperosmolarity **with coma**

E11**.2** Type 2 diabetes mellitus with kidney Complications

E11. 2**1** Type 2 diabetes mellitus

With diabetic nephropathy

E11.2**2** Type 2 diabetes mellitus with diabetic chronic kidney disease

Use additional *code to identify stage of chronic kidney disease (N18.1-N18.6)*

E11.2**9** Type 2 diabetes mellitus with other diabetic kidney complication

E11**.3** Type 2 diabetes mellitus with ophthalmic complications

E11.3**1** Type 2 diabetes mellitus with unspecified diabetic retinopathy

E11.31**1** Type 2 diabetes mellitus with unspecified diabetic retinopathy with macular edema

E11.31**9** Type 2 diabetes mellitus with unspecified diabetic retinopathy without macular edema

Injuries

ICD-10-CM has added a seventh character in the injury category to incorporate the type of encounter. The applicable 7th character is required for all codes within the category, or as the notes in the Tabular List instruct. If a code that requires a 7th character is only 6 characters, a placeholder "X" must be used to fill in the empty characters.

ICD-10-CM Chapter 19: Injury, poisoning, and certain other consequences of external cause (S00-T88)

Current, acute injuries should be coded to the appropriate injury code from chapter 19. Most categories in this chapter have three **7th character values** *(with the exception of fractures)*:

7th character "A," initial encounter, is used while the patient is receiving active treatment for the condition. Examples of active treatment are: surgical treatment, emergency department encounter, and evaluation and treatment by a new physician.

7th character "D," subsequent encounter, is used for encounters after the patient has received active treatment of the condition and is receiving routine care for the condition during the healing or recovery phase. Examples of subsequent care are: cast change or removal, removal of external or internal fixation device,

medication adjustment, other aftercare, and follow up visits following treatment of the injury or condition.

7th character "S," sequela, is for complications or conditions that arise as a direct result of a condition, such as scar formation after a burn. The scars are sequela of the burn.

When applying 7th character "S," use both the injury code that precipitated the sequela and the code for the sequela itself. The "S" is added only to the injury code, not the sequela code. The 7th character "S" identifies the injury responsible for the sequela. The specific type of sequela (e.g. scar) is sequenced first, followed by the injury code.

Categories for traumatic fractures have additional 7th character values.

- A - Initial encounter closed fracture
- B - Initial encounter for open fracture type 1 or II
- C - Initial encounter for open fracture type IIIA, IIIB, or IIIC
- D - Subsequent encounter for closed fracture with routine healing.
- E - Subsequent encounter for open fracture type I or II with routine healing.
- F - Subsequent encounter for open fracture type IIIA, IIIB, or IIIC with routine healing.
- G - Subsequent encounter for closed fracture with delayed healing.
- H - Subsequent encounter for open fracture type I or II with delayed healing.
- J - Subsequent encounter for open fracture type IIIA, IIIB, or IIIC with delayed healing.
- K - Subsequent encounter for closed fracture with nonunion.
- M - Subsequent encounter for open fracture type I or II with nonunion.
- N - Subsequent encounter for open fracture type IIIA, IIIB, or IIIC with nonunion.
- P - Subsequent encounter for closed fracture with malunion.
- Q - Subsequent encounter for open fracture type I or II with malunion.
- R - Subsequent encounter for open fracture type IIIA, IIIB, or IIIC with malunion.
- S - Sequela

If we break this down, we see a pattern that is consistent throughout this category:

- Initial encounter, (A, B, C)
- Subsequent, (D-R)
- Closed or Open Fracture
- If open, describing them as Type I, II, IIIA, IIB or IIC
- Routine healing, (D,E,F)
- Nonunion, (K, M, N)
- Malunion, (P, Q, R)
- Sequela encounter (S)

Seeing this, a coder can easily articulate to the provider the level of detail needed to code for a fracture. There are other nuances specific to fracture care coding; this example demonstrates that even though we have a multitude of codes, the code selection process is very methodical and ICD-10-CM presents the information in a well organized manner.

Example:

S72.322A Displaced transverse fracture of shaft of left femur, initial encounter for closed fracture

S72. The three-character category describes the *ANATOMICAL SITE* of the fracture. ***(FEMUR)***

S72.**3**
The fourth character (3) describes the ***SHAFT*** of the femur. (The specific location on the femur.)

S72.3**2**
The fifth character (2) describes the type of fracture, being ***DISPLACED TRANSVERSE***.

S72.32**2**
The sixth character (2) describes the ***LEFT*** femur

S72.322**A**
The seventh character (A) describes ***INITIAL ENCOUNTER FOR CLOSED*** **fracture**

This demonstrates that each character added provides more information about the patient condition and the type of encounter.

ICD-10-CM Chapter 13 (M00-M99)

Diseases of the Musculoskeletal System and Connective Tissue

There is a distinction between a traumatic injury and a degenerative condition. A chronic dislocation that is not the result of a current, traumatic incident will be located in Chapter 13 of ICD-10-CM. Musculoskeletal conditions such as pain, arthritis, or degenerative conditions are also located here.

ICD-10-CM Official Guidelines for Coding and Reporting 2012, page 43

Pregnancy

Trimester and number of weeks of gestation are required in ICD-10. Obstructed labor codes have added the reason for the obstruction, and 7th character extensions have been added to identify the specific fetus in certain complication codes.

Example:

088. Obstetric **embolism**

088.**1 Amniotic fluid** embolism

088.1**1** Amniotic fluid embolism **in Pregnancy**

088.11**1** Amniotic fluid embolism in Pregnancy **first trimester**

088.11**2** Amniotic fluid embolism in Pregnancy, **second Trimester**

Identification of fetus in complication codes.

064.0xx2 Obstructed labor due to incomplete rotation of fetal head, **fetus 2**

Neoplasm

Additional classifications grouped by morphology have been added. Codes have also been added for leukemia and lymphoma, including codes that designate remission versus personal history.

Remission example:

C92.00 Acute myeloblastic leukemia, **not having achieved remission**
C92.01 Acute myeloblastic leukemia, **in Remission**
C92.02 Acute myeloblastic leukemia, **in** relapse

Personal history
Z85.6 Personal history leukemia

Conditions classifiable to C91-C95
Excludes: Leukemia in remission C91.0-C95.9 with 5th character 1

Terminology

Changes in terminology will also be part of ICD-10-PCS. These changes will create risks for incorrect coding and affect productivity. Initially, there may be a delay in submission of claims due to the aggregate of all of the changes. The extension of the implementation date will allow time to prepare for the changes.

Clinicians may not initially embrace these changes in terminology, and may continued to document as they always have. Hospitals may be educating providers concerning the terminology changes. Ultimately, these terminology changes will affect coders, auditors, and the CDS.

For example, it is unlikely the provider will document "detachment of the lower leg" for a below the knee amputation. It will be the coding professionals who will need to know the category or the association of the new terms to the old.

Providers will need to make some changes in the documentation, particularly to provide details, as previously discussed. The terminology changes will have more impact on the coding and auditing professionals, as well as the CDS. To ensure correct code selection, the coder will need to familiarize him- or herself with this new language.

Examples of procedural terminology changes:

ICD-9	ICD-10
Amputation	Detachment
Amniocentesis	Aspiration/Drain
Arthroscopy	Inspection or Endoscopic Approach
Cesarean Section	Extraction of the Products of Conception
Closed reduction	Reposition
Debridement	Excision, Extraction Irrigation, Extirpation
Radical Mastectomy	Resection RT, LT -Bilateral
Subtotal Mastectomy	Excision
Tonsillectomy	Resection of Tonsils
Tracheostomy	Bypass

Management Activity ICD-10 News Flash "International Classification of Diseases – Tenth Revision (ICD-10)"
"Terminology Changes in ICD-10-PCS"

Summary ICD-10

ICD-10 codes provide greater specificity with diagnosis and procedure coding. Documentation must provide the details needed to code with the new system.

Examples:

- Laterality
- Episode of care
- New terminology
- Details of body parts
- Approach
- Methodology
- Devices used in procedures
- Other qualifying information

This is a very short list of details for required documentation with ICD-10. Assessments by the AAPC revealed that only 65 percent of today's documentation is ready for the change. CDS have been given additional time to prepare with the recent 12-month delay in the implementation of ICD-10. Documentation improvement will be a one of the main objectives in preparing for this change.

Potential categories at risk for insufficient documentation ICD-10-PCS

With ICD-10, requirements for time frames have been added to certain codes. Respiratory/ventilator codes now distinguish whether the patient has been on a ventilator for:

- Less than 24 consecutive hours
- 24-96 consecutive hours
- More than 96 consecutive hours

Let's look at an example. 5A1955Z is used for coding respiratory mechanical ventilation, greater than 96 consecutive hours. The explanation of this code is found below:

Character 1 Section	**Character 2** Body System	**Character 3** Root Operation	**Character 4** Body System	**Character 5** Duration	**Character 6** Function	**Character 7** Qualifier
5	**A**	**1**	**9**	**5**	**5**	**Z**
Extracorporeal Assistance and Performance	Physiological Systems	Performance	Respiratory	Greater than 96 hours	Ventilation	No Qualifier

Ingenix. *Comprehensive Anatomy and Physiology for ICD-10-CM Coding.* Ingenix, 2011.

Chapter 6:

Coding and Abstracting

Coding is the process of translating the physician clinical documentation into diagnostic and procedural coded data. Coding is essentially a language unto itself. The level of detail required in the coding system is one justification for detail in the clinical documentation.

Coding guidelines vary based on the provider's setting; guidelines for the outpatient physician office setting are different than those for patients in the inpatient hospital setting. Although the coding guidelines vary, the criteria for high quality clinical documentation remain consistent across all settings.

The provider has a responsibility to ensure the documentation is comprehensive enough to support the coding and reporting process to minimize incorrect payments. Coding errors increase when there is no accountability for documentation and coding.

There must be oversight and awareness of obligations by everyone involved in the process of documentation, coding, and claim reporting. The CDS ensures a level of integrity and accuracy with documentation and coding.

> *"Innocent billing errors are a significant drain on the Federal health care programs. All parties (physicians, providers, carriers, fiscal intermediaries, Government agencies, and beneficiaries) need to work cooperatively to reduce the overall error rate. Finally, it is reasonable for physicians (and other providers) to ask: what duty do they owe the Federal health care programs? The answer is that* ***all health care providers have a duty to reasonably ensure that the claims submitted to Medicare and other Federal health care programs are true and accurate****.*
>
> *The OIG continues to engage the provider community in an extensive, good faith effort to work cooperatively on voluntary compliance to minimize errors and to prevent potential penalties for improper billings before they occur.*
>
> *Federal Register/Vol. 65, No. 194/Thursday, October 5, 2000/Notices*

The detail of documentation facilitates the abstracting process of coding. The coder may have to report the lowest valued code because the details in the report do not allow for a higher level. For instance, if the length and/or depth of a repair are not reported in the record, the coder's options are to code the CPT® code describing the shortest length (lowest value), or to hold the claim until the provider dictates an addendum with enough details to code correctly.

Example:

A patient presents to the ER with multiple lacerations following a bicycle accident. The provider documents the repair of a superficial laceration on the patient's left forearm and an 11 cm laceration on the patient's left calf. The provider meticulously debrides the laceration on the lower extremity of all foreign debris and devitalized tissue, thoroughly irrigated the wound with antibiotic solutions and closed with 2-0 Vicryl suture. After closures were complete, sterile dressings are applied and the patient was instructed on wound care and told to follow-up with his PCP.

The repair codes are described as Simple, Intermediate, and Complex repairs.

- Simple repairs 12001-12021
- Intermediate repairs 12031-12057
- Complex repairs 13100-13160

CPT® instructs coders to code to a higher degree if the wound is contaminated, requiring substantial debridement. For this reason it is important that providers document the degree of contamination.

The laceration on the forearm was closed and dressed with a sterile dressing. Because the provider only stated "superficial wound on the left forearm," without any length or type of closure, the forearm laceration could be:

1) Bundled into the ER visit, if closed with surgical glue or butterfly strips
2) Coded as a simple repair with CPT® 12001.
3) Knowing that the lower extremity wound was contaminated with foreign debris, one may reason that the upper extremity could have been contaminated, as well. This could change the code category to an intermediate closure of a contaminated superficial wound. Not knowing the length we would have to code 12031.

Because the details were not complete for the lower extremity, the coder is confronted with several possible scenarios.

1) Code as an intermediate repair of an 11 cm superficial contaminated wound (12034)
2) Code as a complex repair of an 11 cm intermediate contaminated wound (13121 and 13122)

Adding to the complexity of this seemingly simple example is one more coding possibility. If the forearm is an intermediate repair of a superficial contaminated wound, and the lower extremity is an intermediate repair of a superficial contaminated wound, the coder would have to add the length of both wounds together and select a code from 12034-12037.

This case clearly demonstrates the need for complete, detailed documentation.

Frequently, ER coding is outsourced or the coding department is remote. Holding the claim for additional information may delay the billing for an extended time.

If the provider completed a billing sheet with code 12005 and the documentation did not specifically state the laceration was between 12.6 and 20 cm long, the coder still cannot process/bill the claim. A billing sheet is not sufficient documentation for code selection. The medical record must stand alone and provide the details of the procedures.

Another example is when the coder must select "unspecified" diagnoses codes, or codes listed as "NOS" (not otherwise specified) because there is insufficient detail to warrant coding to a higher level of specificity. For instance, the record states "Acute Respiratory Infection." The only code that can be reported is 465.9 *Acute URI NOS*.

Coding and Abstracting Go Hand In Hand

The coder must use the text document to code the services.

Example: 1

The patient presents to the office with severe pain in the right lower leg. The provider documented suspected meniscal tear as the diagnosis and sent it to the staff for data entry.

This example is an indication the provider does not understand the coding guidelines for outpatient ICD-9 coding.

The guidelines specifically state a diagnosis of a "suspected" or "possible" condition, or one to be "ruled out," cannot be the first listed code. When the diagnosis is not confirmed, the signs and symptoms that prompted the patient to present to the office would be reported.

The documentation does state pain in the right knee, which is the symptom of the "suspected" meniscal tear. The provider should report pain in the knee as the diagnosis on the fee ticket, charge sheet, or electronic charge ticket. As fundamental as this example is, this type of diagnoses reporting is common in many practices.

There are many types of forms and documents a CDS will need to review for compliance. The assessment of the operational procedures from the appointment calls to the payments of the claim is important, as well. In this case, the data entered by the support staff would be meniscal tear. Also in this example, there is no indication as to the tear being acute or chronic.

Example: 2

The patient presents to the office with severe pain in the right lower leg. The 55-yr-old male, who appears to be withdrawn, is somewhat anxious and concerned that he "messed up his knee really bad." His pain is an 8 on a scale from 1-10. He reports that he fell down a flight of stairs last night. He experienced immediate throbbing pain and swelling in the right knee. He is unable to bear weight on the leg and is having difficulty walking. He has a gash on his left leg. X-rays reveal no acute bony abnormality to either knee. He has restricted range of motion due to his pain. Sensation in the lower extremities is intact. Distal pulses are strong with good capillary refill.

In this example, we see much better detail. The patient fell down stairs causing the right knee pain. The pain is so severe that he is unable to bear weight and is having difficulty walking; however, we do not see detail of the "gash" on the left leg. What did the provider do concerning the "gash?" Was this repaired in the office? How deep was the "gash?" Were X-rays performed in the provider's office during this encounter? He does not mention the patient having prior treatment for this injury.

If X-rays were performed in the office, there is no indication of how many views were taken. It is inferred by the word "either" knee that both knees were X-rayed. It is not clear if the patient brought the X-rays with him, or if they were performed in the physician's office.

Looking at all of the questions listed above, one can see how much information is still missing. Additionally, this documentation does not look patient centered.

Example: 3

The patient presents to the office with severe pain in the right lower leg. He is a new patient to the office. He is a 55-yr-old male who appears to be withdrawn (ROS). He is concerned that he "messed up his knee really bad." His

pain is an 8 on a scale from 1-10. (HPI) He reports that he fell down a flight of stairs last night. (HPI) He experienced immediate throbbing pain and swelling (HPI). He is unable to bear weight on the right leg. (HPI) and is having difficulty walking. He denies loss of consciousness after the fall, or any dizziness (ROS) prior to the fall. He states he just slipped, lost his balance, and fell down the steps. He has no other musculoskeletal complaints. (ROS) He has 6 cm laceration on his LEFT leg involving the subcutaneous tissue only. (EXAM) He has a history of diabetes, which is well controlled. (ROS) He in a non-smoker. He is employed as an inspector with the county fire department. (Social Hx.) His medical history is reviewed and is scanned into the record. There are no pertinent findings on his ROS, other than those just mentioned. His RIGHT leg shows no evidence of lacerations or bruising. He has restricted range of motion due to his pain in the right, knee. There are no signs of instability or muscle weakness on the right. He is tender on the anterior and medial joint.

ROM, muscle strength, and joint stability on the LEFT is normal. Sensation in the lower extremities is intact. Distal pulses are strong with capillary refill < 3 seconds bilaterally. The laceration was cleaned and sutured closed with local infiltration of 4 cc of 1.0 % Xylocaine without difficulty.

X-rays taken in the office today, to include AP and Lateral views of the right and left knee, reveal no acute bony abnormality. Due to the clinical findings, I am ordering an MRI of the right knee. He is not allergic to any drugs. He has taken Lortab before without complications and it seemed to relieve his pain. He is given Lortab 7.5 mg to take 1-2 tabs every four to six hours, as needed for pain.

He is sent to PT for crutch training, instructed in "RICE." We will follow-up with him as soon as we have the MRI. He understands the instructions given and will call the office if he has any problems prior to his next appointment. He is given a note not to return to work for at least five days. We should have the results of the MRI by then.

X-Ray Report: AP and lateral view Right knee … (formal written report)...

X-Ray Report: AP and lateral view Left knee … (formal written report)…

In this example, we see even better detail. Abstracting the correct codes is much easier. We now see the provider repaired the "laceration" on the left leg. This involved the subcutaneous tissue and was closed after cleansing and local filtration of 4 cc of 1.0 % Xylocaine. For those wishing to bill the supply, the unlisted code must be used (payment policies vary with each payer). This supply is normally considered incident to the repair.

In this example for the exam we see:

HPI:

1. Severity: pain 8 (1-10)
2. Timing: last night
3. Quality: throbbing
4. S&S: Swelling
5. M-F or Context: Unable to bear weight. Injury could also be counted as context.

We only need four elements of the HPI to be extended, which will qualify for the highest-level code.

ROS:

1. Neurological: denies dizziness or loss of consciousness
2. Musculoskeletal: No other M/S complaints
3. Endocrine: Diabetes
4. Constitutional: WDWN. This could be counted as an exam element instead because it is an observation made by the provider.

Additionally, we have the intake form provided by the patient, which should qualify—if designed and completed correctly—for a comprehensive level of code selection.

Only two elements of the ROS are required to qualify for an extended ROS, which is a detailed level or code.

PFS History

Past Medical:

Family:

Social: Non-smoker, Employment details

The PFS history component qualifies for the detailed level of code selection. Only one pertinent PFS history component is required for the detailed level.

The overall level of History for this example is detailed.

Looking at the exam, we see much better detail in this example. Many EMRs are templated to assist with standard exam elements for specific conditions. That the patient is a new patient and has an acute injury warrants a more detailed exam.

The exam demonstrates:

4 organ systems,

1. Cardiovascular
2. Neurological
3. Integumentary
4. Musculoskeletal

You can count 2 body areas instead of the musculoskeletal system

1. Right lower extremity
2. Left lower extremity

Right lower extremity:

1. Skin: Negative for lacerations or bruising
2. ROM: Limited due to pain
3. Joint stability: Negative for instability
4. Muscle weakness: Negative
5. Palpation: Tender anterior, medial joint
6. Neurological: Normal sensation
7. Cardiovascular: Normal distal pulse

Left Lower extremity:

1. ROM: Normal
2. Joint stability: Normal
3. Muscle Strength: Normal
4. Skin: 6 cm laceration superficial laceration.
5. Neurological: Normal sensation (already counted for the right lower extremity)
6. Cardiovascular: Normal distal pulse (already counted for the right lower extremity)

Within the four organ systems, or three organ systems and two body areas, 11 elements are documented. This will qualify for a detailed exam for 1995 and expanded problem focused for 1997.

1995 DG. *Detailed*: an extended examination of the affected body area(s) and other symptomatic or related organ system(s).

1997 DG. *Expanded problem focused*: Includes performance and documentation of at least six elements identified by a bullet in one or more organ system(s) or body area(s).

It is VERY important that coders know the guidelines that their specific MAC uses when auditing. Some MACS may not quantify this as a detailed exam. There is a "four of four requirement" by some MACS and payers for the detailed exam elements for the 1997 E/M guidelines. If audited by this standard, the office visit would qualify for 99202, Expanded Problem Focus.

We do see from a Medical Decision Making (MDM) standpoint the presenting problem is at a Moderate level of complexity. As noted before, the provider has already documented an Extended HPI, and ROS is extended at a minimum (without the patient intake form).

MDM:

1. New patient with additional work up
2. Acute injury
3. RX drug management
4. Order X-ray

We can see in this example how just a few additional details in documentation can support more specific coding. These diagnoses will support a higher level of E/M code than simply knee pain. It is easy to see how this documentation and subsequent coding is a building process; however, correct coding cannot be performed or audited without detailed accurate documentation.

In the example we see the code for the E/M will be a new patient code. He presents in the office, so we know the POS will be 11. His laceration is on the left leg. The major injury was to the right knee. We know the laceration is separately identifiable and can be coded in addition to the office visit. Modifier 25 should be appended to the office visit.

CPT®

99203-25

12001

73560-50

Diagnoses

1) 719.46 Pain in the knee joint

2) 719.7 Difficulty walking

3) 891.0 Open wound without mention of complication

4) E880.9 Fall from stairs or steps

Most importantly, this example is more patient centered:

- The HPI and ROS clearly indicate the provider questioned the patient about the accident.
- The provider was concerned about other conditions that could have caused the accident or happened as the result of the accident.

- He questioned the patient about his diabetes, noting this to be well controlled. Diabetes impacts healing and may play a role in the plan of care.
- The provider is managing his pain with Rx management. There is evidence he asked the patient about any previous allergies or complications with, and the effectiveness of, taking Lortab.
- He is sending him for crutch training.
- Giving the patient instructions concerning rest, ice, compresses, and elevation to assist with pain control.
- The provider questioned the patient about his work activities. He made decisions concerning his ability to work due to his pain level, the medication he was providing, and that he would be non weight bearing.
- He also provided the patient with a note for his work status.
- He noted the patient understood his instructions, and encouraged him to call the office if he has any problems.
- If support staff or another provider reviews the record, they would have a very clear understanding of the patient's complaint, condition, and the provider's plan of care.

Coding and Billing Risk Areas for Physician Practices.

The following risk areas associated with billing have been among the most frequent subjects of investigations and audits by the OIG:

- Billing for items or services not rendered or not provided as claimed
- Double billing, resulting in duplicate payment
- Submitting claims for equipment, medical supplies, and services that are not reasonable and necessary. Billing for services, supplies and equipment that are not reasonable and necessary involves seeking reimbursement for a service that is not warranted by a patient's documented medical condition. See 42 U.S.C. 1395i (a)(1)(A): "No payment may be made under part A or part B [of Medicare] for any expenses incurred for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of the malformed body member"
- Billing for non-covered services as if covered
- Knowing misuse of provider identification numbers, which results in improper billing.
- Unbundling (billing for each component of the service instead of billing or using an all-inclusive code)
- Failure to properly use coding modifiers;
- Clustering
- Upcoding the level of service

Federal Register/Vol. 65, No. 194/Thursday, October 5, 2000/Notices page 55439

Chapter 7:

The Implementation of a CDI Plan

Professionals who assist in ensuring the quality, accuracy, and integrity of the medical record are in great demand. Documentation improvement is far reaching and may involve several people or several departments within your organization to be a comprehensive, effective plan. Designate an individual to oversee the documentation improvement process.

- Assign a physician advocate and the compliance officer to assist with the management and enforcement of the policies.
- Employ a coder and/or auditor to manage aspects of the documentation improvement process associated with coding, billing, and reimbursement (This teamwork uses the skills and expertise of the coding and auditing professionals when the CDI process overlaps). Involve all departments that play a role in the documentation process (nurses, data entry staff, etc.).
- Assign one individual in each department the responsibility of working with the CDS to assist in resolving documentation issues for that department.
- Identify the practice/facility needs within each department.
- Work with the highest risk area first, utilizing authoritative guidelines and instructions.
- Develop policies and protocols that meet the needs of your practice that are effective but not overwhelming. For example, policies for:
  - Adding late entries
  - Corrections to medical records
  - Timeliness of documentation
  - Who has the permission to input data in the EMR
  - Policies concerning the use of acronyms

  - Policies for risk prevention
- Create templates that will assist with better detail and compliance with specialty specific documentation mandates.
- Review provider reports based on the quality and accuracy of information.
- Schedule regular educational meetings for CDI team, providers, and staff.
- Perform regular audits for monitoring.
- Monitor the policies and procedures for effectiveness, and change when needed.

Conducting Appropriate Training and Education

Education is an important part of any compliance program and is the logical next step after problems have been identified and the practice has designated a person to oversee educational training.

Ideally, education programs will be tailored to the physician practice's needs, specialty, and size, and will include both compliance and specific training.

There are three basic steps for setting up educational objectives:

1) Determine who needs training (both in coding and billing and in compliance);
2) Determine the type of training that best suits the practice's needs (e.g., seminars, in-service training, self-study, or other programs); and
3) Determine when and how often education is needed, and how much each person should receive.

Training may be accomplished through a variety of means, including in-person training sessions (i.e., either on site or at outside seminars), distribution of newsletters, or even a readily accessible office bulletin board. Regardless of the training modality used, a physician practice should ensure that the necessary education is communicated effectively and that the practice's employees come away from the training with a better understanding of the issues covered.

Federal Register/Vol. 65, No. 194/Thursday, October 5, 2000/Notices page 59442

Enforcement of Protocols

There must be a process to enforce the protocols that are put in place as preventive measures. This can be part of the CDI's responsibility, or the responsibility of the practice/facility manager. Some actions that can be taken to enforce compliance are:

- Holding the claim for processing until all documentation deficiencies are resolved. The providers are aware claims will not be processed until the requested information is provided to the billing staff.
- In severe cases of deficient documentation, have a CDS review all records prior to coding and processing of claims.
- Employ scribes to document the services at the time the services are rendered, until the provider is amenable to the internal policies and procedures the practice has in place.

Quick response and action for all detected deficiencies are required to facilitate an effective protocol. If the policies and procedures developed by the practice are not adhered to, the entire process will be devalued.

Above are suggestions for practical applications in developing a CDI plan. Each plan must be tailored to meet the unique needs of the entity/specialty. Adhering to state, federal, and individual payer mandates is paramount; however, patient care is the overarching objective for CDI.

CDI is a project that will continuously evolve as changes continue. The need for CDI will never go away—the demand will only increase.

Medicare Learning Network
MLN Matters®
CMS
Information for Medicare Fee-for-Service Health Care Professionals

News Flash – The Centers for Medicare & Medicaid Services (CMS) reminds all providers, physicians, and suppliers to allow sufficient time for the Medicare crossover process to work—approximately 15 work days after Medicare's reimbursement is made, as stated in MLN Matters Article SE0909 (***http://www.cms.gov/MLNMattersArticles/downloads/SE0909.pdf***) — before attempting to balance bill their patients' supplemental insurers. That is, do not balance bill until you have received written confirmation from Medicare that your patients' claims will not be crossed over, or you have received a special notification letter explaining why specified claims cannot be crossed over. Remittance Advice Remark Codes MA18 or N89 on your Medicare Remittance Advice (MRA) represent Medicare's intention to cross your patients' claims over.

MLN Matters® Number: MM6698 Revised
Related Change Request (CR) #: 6698
Related CR Release Date: March 16, 2010
Effective Date: March 1, 2010
Related CR Transmittal #: R327PI
Implementation Date: April 16, 2010

Signature Guidelines for Medical Review Purposes

Note: This article was revised on June 16, 2010 to include on pages 6-7 a table excerpted from CR 6698 that summarizes signature requirements. All other information is the same.

Provider Types Affected

This article is for physicians, non-physician practitioners, and suppliers submitting claims to Medicare Fiscal Intermediaries (FIs), Part A/B Medicare Administrative Contractors (A/B MACs), Carriers, Regional Home Health Intermediaries (RHHIs), and/or Durable Medical Equipment MACs (DME MACs) for services provided to Medicare beneficiaries.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued CR 6698 to clarify for providers how Medicare claims review contractors review claims and medical documentation submitted by providers. CR 6698 outlines the new rules for signatures and adds language for E-Prescribing. See the rest of this article for complete details. These revised/new signature requirements are applicable for

reviews conducted on or after the implementation date of April 16, 2010. **Please note that all signature requirements in CR 6698 are effective retroactively for Comprehensive Error Rate Testing (CERT) for the November 2010 report period.**

Background

Those contractors who review Medicare claims include MACs, Affiliated Contractors (ACs), the CERT contractors, Recovery Audit Contractors (RACs), Program Safeguard Contractors (PSCs), and Zone Program Integrity Contractors (ZPICs). These contractors are tasked with measuring, detecting, and correcting improper payments as well as identifying potential fraud in the Fee for Service (FFS) Medicare Program.

The previous language in the Program Integrity Manual (PIM) required a "legible identifier" in the form of a handwritten or electronic signature for every service provided or ordered. CR 6698 updates these requirements and adds E-Prescribing language.

For medical review purposes, Medicare requires that services provided/ordered be authenticated by the author. The method used must be a hand written or an electronic signature. Stamp signatures are not acceptable. There are some exceptions, i.e.:

EXCEPTION 1: Facsimiles of original written or electronic signatures are acceptable for the certifications of terminal illness for hospice.

EXCEPTION 2: There are some circumstances for which an order does not need to be signed. For example, orders for clinical diagnostic tests are not required to be signed. The rules in 42 CFR 410 and the Medicare Benefit Policy Manual, chapter 15, section 80.6.1, state that if the order for the clinical diagnostic test is unsigned, there must be medical documentation by the treating physician (e.g., a progress note) that he/she intended the clinical diagnostic test be performed. This documentation showing the intent that the test be performed must be authenticated by the author via a handwritten or electronic signature.

EXCEPTION 3: Other regulations and CMS instructions regarding signatures (such as timeliness standards for particular benefits) take precedence. For medical review purposes, if the relevant regulation, NCD, LCD and CMS manuals are silent on whether the signature be legible or present and the signature is illegible/missing, the reviewer shall follow the guidelines listed below to discern the identity and credentials (e.g.MD, RN) of the signator. In cases where the relevant regulation, NCD, LCD and CMS manuals have specific signature requirements, those signature requirements take precedence.

MLN Matters® Number: MM6698 **Related Change Request Number: 6698**

The AC, MAC and CERT reviewers shall apply the following signature requirements:
If there are reasons for denial unrelated to signature requirements, the reviewer need not proceed to signature authentication. If the criteria in the relevant Medicare policy cannot be met but for a key piece of medical documentation which contains a missing or illegible signature, the reviewer shall proceed to the signature assessment.

Providers should not add late signatures to the medical record, (beyond the short delay that occurs during the transcription process) but instead may make use of the signature authentication process.

Keep in mind that a handwritten signature is a mark or sign by an individual on a document to signify knowledge, approval, acceptance or obligation and note the following:

- If the signature is illegible, ACs, MACs, PSCs, ZPICs and CERT shall consider evidence in a signature log or attestation statement to determine the identity of the author of a medical record entry.
- If the signature is missing from an order, ACs, MACs, PSCs, ZPICs and CERT **shall disregard the order** during the review of the claim.
- If the signature is missing from any other medical documentation, ACs, MACs, PSCs, ZPICs and CERT shall accept a signature attestation from the author of the medical record entry.

The following are the signature requirements that the ACs, MACs, RACs, PSCs, ZPICs, and CERT contractors will apply:

- Other regulations and CMS instructions regarding signatures (such as timeliness standards for particular benefits) take precedence.
- **Definition of a handwritten signature** is a mark or sign by an individual on a document to signify knowledge, approval, acceptance or obligation.
- For medical review purposes, if the relevant regulation, NCD, LCD, and other CMS manuals are silent on whether the signature must be dated, the reviewer shall review to ensure that the documentation contains enough information for the reviewer to determine the date on which the service was performed/ ordered. **EXAMPLE:** The claim selected for review is for a hospital visit on October 4. The Additional Documentation Request (ADR) response is one page from the hospital medical record containing three entries. The first entry is dated October 4 and is a physical therapy note. The second entry is a

physician visit note that is undated. The third entry is a nursing note dated October 4. The reviewer may conclude that the physician visit was conducted on October 4.

- **Definition of a Signature Log:** Providers will sometimes include, in the documentation they submit, a signature log that identifies the author associated with initials or an illegible signature. The signature log might be included on the actual page where the initials or illegible signature are used or might be a separate document. Reviewers will consider all submitted signature logs regardless of the date they were created.
- **Definition of an Attestation Statement:** In order for an attestation statement to be considered valid for Medicare medical review purposes, the statement must be signed and dated by the author of the medical record entry and contain the appropriate beneficiary information.
- Providers will sometimes include in the documentation they submit an attestation statement. In order to be considered valid for Medicare medical review purposes, an attestation statement must be signed and dated by the author of the medical record entry and must contain sufficient information to identify the beneficiary. Should a provider choose to submit an attestation statement, they may choose to use the following statement: "I, _____[print full name of the physician/practitioner]___, hereby attest that the medical record entry for _____[date of service]___ accurately reflects signatures/notations that I made in my capacity as _____[insert provider credentials, e.g., M.D.]___ when I treated/diagnosed the above listed Medicare beneficiary. I do hereby attest that this information is true, accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability."
- While this sample statement is an acceptable format, at this time, CMS is neither requiring nor instructing providers to use a certain form or format. A general request for signature attestation shall be considered a non-standardized follow-up question from the contractors to the providers so long as the contractors do not provide identical requirements or suggestions for the form or format of the attestation. The above format has not been approved by the Office of Management and Budget (OMB) and therefore it is not mandatory. However, once OMB has assigned an OMB Paperwork Reduction Act number to this attestation process, a certain form/format will be mandatory.
- Claims reviewers will not consider attestation statements where there is no associated medical record entry or from someone other than the author of the medical record entry in question. Even in cases where two individuals are in the same group, one may not sign for the other in medical record entries or

attestation statements.

- If a signature is missing from an order, claims reviewers will disregard the order during the review of the claim.
- Reviewers will consider all attestations that meet the guidelines regardless of the date the attestation was created, except in those cases where the regulations or policy indicate that a signature must be in place prior to a given event or a given date.
- The following are the signature guidelines in section 3.4.1.1.B.c as shown in the manual revision attachment of CR 6698:
    - In the situations where the guidelines indicate "**signature requirements met**," the reviewer will consider the entry.
    - In situations where the guidelines indicate "**contact provider and ask a non-standard follow up question,"** the reviewer will contact the person or organization that billed the claim and ask them if they would like to submit an attestation statement or signature log within 20 calendar days. The 20 day timeframe begins once the contractor makes an actual phone contact with the provider or on the date the request letter is received at the post office. (Reviewers will not contact the provider if the claim should be denied for reasons unrelated to the signature requirement.)
    - In the situations where the guidelines indicate "**signature requirements NOT met**," the reviewer will disregard the entry and make the claims review determination using only the other submitted documentation.

Electronic Prescribing

Electronic prescribing (e-prescribing) is the transmission of prescription or prescription-related information through electronic media. E-prescribing takes place between a prescriber, dispenser, pharmacy benefit manager (PBM), or health plan. It can take place directly or through an e-prescribing network. With e-prescribing, health care professionals can electronically transmit both new prescriptions and responses to renewal requests to a pharmacy without having to write or fax the prescription. E-prescribing can save time, enhance office and pharmacy productivity, and improve patient safety and quality of care. Note the following key points:

- Reviewers will accept as a valid order any Part B drugs, other than controlled substances, ordered through a qualified E-Prescribing system. For Medicare Part B medical review purposes, a qualified E-Prescribing system is one that

meets all 42 CFR 423.160 requirements. To review the official standards for electronic prescribing, *42 CFR 423.160 Standards for Electronic Prescribing,* you may go to ***http://edocket.access.gpo.gov/cfr_2008/octqtr/pdf/42cfr423.160.pdf*** on the Internet.

- When Part B drugs, other than controlled substances, have been ordered through a qualified E-Prescribing system, the reviewer will NOT require the provider to produce hardcopy pen and ink signatures as evidence of a drug order.
- At this time, AC, MAC, CERT, PSC, and ZPIC reviewers shall NOT accept as a valid order any controlled substance drugs that are ordered through any E-Prescribing system, even one which is qualified under Medicare Part D. When reviewing claims for controlled substance drugs, the reviewer shall only accept hardcopy pen and ink signatures as evidence of a drug order.
- At this time, the AC, MAC, CERT, PSC and ZPIC reviewers shall accept as a valid order any drugs incident to DME, other than controlled substances, ordered through a qualified E-Prescribing system. For the purpose of conducting Medicare medical review of drugs incident to DME, a qualified E-Prescribing system is one that meets all 42 CFR 423.160 requirements. When drugs incident to DME have been ordered through a qualified E-Prescribing system, the reviewer shall NOT require the provider to produced hardcopy pen and ink signatures as evidence of a drug order.

Additional Information

CR 6698 includes a helpful table that summarizes the situations where signature requirements are met and/or a Medicare contractor may contact the provider to determine if the provider wishes to submit an attestation statement or signature log. Key portions of that table are as follows:

		Signature Requirement Met	Contact billing provider and ask a non-standardized follow up question
1	Legible full signature	X	
2	Legible first initial and last name	X	
3	Illegible signature over a typed or printed name	X	

MLN Matters® Number: MM6698 **Related Change Request Number: 6698**

4	Illegible signature where the letterhead, addressograph or other information on the page indicates the identity **o**f the signator. Example: An illegible signature appears on a prescription. The letterhead of the prescription lists 3 physicians' names. One of the names is circled.	X	
5	Illegible signature NOT over a typed/printed name and NOT on letterhead, but the submitted documentation **is accompanied** by: 1) a signature log, or 2) an attestation statement	X	
6	Illegible Signature NOT over a typed/printed name, NOT on letterhead and the documentation is **UNaccompanied** by: a) a signature log, or b) an attestation statement		X
7	Initials over a typed or printed name	X	
8	Initials NOT over a typed/printed name but **accompanied** by: a) a signature log, or b) an attestation statement	X	
9	Initials NOT over a typed/printed name **UNaccompanied** by: a) a signature log, or b) an attestation statement		X
10	Unsigned typed note with provider's typed name Example: John Whigg, MD		X
11	Unsigned typed note without providers typed/printed name		X
12	Unsigned handwritten note, the only entry on the page		X
13	Unsigned handwritten note where other entries on the same page in the same handwriting are signed.	X	
14	"signature on file"		X

MLN Matters® Number: MM6698 **Related Change Request Number: 6698**

If you have questions, please contact your Medicare FI, carrier, A/B MAC, RHHI or DME MAC at their toll-free number which may be found at ***http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*** on the CMS website.

The official instruction, CR6698, issued to your Medicare FI, carrier, A/B MAC, RHHI or DME MAC regarding this change may be viewed at ***http://www.cms.gov/Transmittals/downloads/R327PI.pdf*** on the CMS website.

Exercise 1—E-Medical Record Documentation Review

Date of Exam: 9/26/2011
Provider: Timothy Cooper M.D.
Provider NPI: 1576497934
Patient Name: Jessica Hughes
Date of Birth: 6/16/1950

Allergies: BACTRIMDS microdantinmicrodantinmicrodantin
Medications: Estrogen*
Past History:
Medical History: No Medical History Reported.
Surgical History: No Surgical History Reported
Family History: Father has history of cancer and copd pancreatic cancer. Mother has history of cancer and ami.
Social History: Patient is right handed. Patient does not use tobacco.

Review of Systems:

• Constitutional symptoms (e.g., fever, weight loss)	No fever, fatigue, weakness or sudden weight change
• Eyes	Patient has history of glasses or contacts.
• Ears, Nose, Mouth, Throat	No abnormal auditory acuity, no nasal discharge or difficulty swallowing
• Cardiovascular	chest pains or palpations or high blood pressure
• Respiratory	No shortness of breath or cough
• Gastrointestinal	No abdominal pain, heartburn, hepatitis or bleeding
• Genitourinary	No dysuria or hematuria
• Musculoskeletal	No generalized joint pain, stiffness, weakness or muscle pain
• Integumentary (skin and/or breast)	No rashes or jaundice
• Neurological	No headache, dizziness or memory loss
• Psychiatric	No mood change, depression or nervousness
• Endocrine	No thyroid enlargement, sweating or excessive thirst
• Hematologic/Lymphatic	No bruising, swollen glands or anemia
• Allergic/Immunologic	No skin rashes, or allergies to food or medication

Chief Complaint: See previous

History of Present Illness: She comes in today in follow-up. She is doing much better. Swelling has reduced. She is more comfortable.

Exam

Ankle Exam: Inspection:

Gait: The gait is antalgic.

Skin Right: Normal

Skin Left: Normal

	Right	Left
Ecchymosis	Negative	Negative
Swelling	Negative	Mild
Hindfoot	Neutral	Neutral
Midfoot Forefoot	Neutral	Neutral
Toes	Neutral	

	Right	Left
Palpation	Non-tender	Tenderness
Homan's sign	Negative	Negative
Morton's Test	Negative	Negative
Pulse Dorsalis	5/5	5/5
Pulse Post Tibial	5/5	5/5

Muscle Testing	Right	Left
Plantar Flexion	5/5	5/5
Dorsalis	5/5	5/5
Foot Inversion	5/5	5/5
Foot Eversion	5/5	5/5
Neurological	Normal reflexes and distal sensation	

Special Testing:	Right	Left
Anterior Drawer		Stable
TalarTilt		Stable
Thompson Test		Positive
O'Brien's Test		Positive

ROM ACTIVE

Description Left Side: Active range of motion restricted due to pain.

Description Right Side: Normal pain-free active range of motion.

Description Left Side: Passive range of motion restricted due to pain.

Description Right Side: Normal pain-free passive range of motion.

Imaging

Left Foot 3 VIEWS: I ordered foot x-rays today, taken in the office, I have reviewed AP, lateral and oblique views. X-rays reveal a non displaced fracture of the 2nd and 3rd metatarsal shafts with very slight callus formation. The joint spaces appear normal. There is an appearance of osteopenia throughout the structure of the foot.

Impression

Fracture 2nd & 3rd MT shafts

Plan

Continue wearing fracture boot. Bear weight to tolerance within the limits of pain. She already has crutches and pain medication. I will keep her off work for another two 2 weeks. See her back in two weeks.

_____

Electronically signed

Appendix B

Clinical Documentation Evaluation and Management Review			
NAME	**Yes**	**No**	**Comments**
First			Ea. Page Yes ___ No___
Last			Ea. Page Yes ___ No___
Middle			Ea. Page Yes ___ No___
Date of Service			
Date of Birth			
Practice Name / Identifiers			
Allergy "Current"			Date:
Current Problem list			
Chronic Conditions			
Medication list			
Renewal Hx.			
Physician Notes:			
Exam/Clinical findings			
Chief Complaint			
Preventive information Hx. if PCP			
Immunizations if applicable			
ROS: Positive and Negative			
Major health risks			
Prior unresolved /current conditions			
Patient compliance and response to treatment			
Provider Plan of Care			
Patient Education			
Follow-up Instructions			
Evidence of patient understandings instructions			
Rx. w/ name /dose /instructions			
Physician Signature			
Physician typed or printed name.			
Counter-Signature			
Tests results/initialed/acknowledged			
Evidence patient was notified of results			
Signature or acknowledgement in the note of the review of medical intake forms completed by patient			
Evidence of coordination of care.			
Medical necessity for orders on specified plan of care			
Notation of follow-up / PRN /D/C			
Diagnosis for current encounter			
Co-Morbidities impacting care/ outcome			
Documentation completed same date of encounter			
Coded services documented			
Electronic : _____ Hard Copy _____			
Comments:			
Date Reviewed: Reviewed By:			

Document Assessment

Record # Date Of Service _____ Provider _____

Patient Name:_____ Payer:_____

Component	New Patient Visit Each Component is Required All 3 Must Meet/or Exceed				
History	PF	EPF	D	C	C
Examination	PF	EPF	D	C	C
Medical Decision Making	SF	SF	L	M	H
Level of service	99201	99202	99203	99204	99205
Time **See below	10	20	30	45	60

Component	Established Patient Visit Two Components Are Required—2 Must Meet/or Exceed				
History	Minimal	PF	EPF	D	C
Examination	physician presence not required	PF	EPF	D	C
Medical Decision Making	Minimal	SF	L	M	H
Level of service	99211	99212	99213	99214	99215
Time **See below	5	10	15	25	40

Components

History Level _____

Examination Level _____

Medical Decision Making Level _____

Level of Visit Reported _____

Level of Visit Reviewed _____

☐ **See attached documents for detailed explanation**

Comments

_____

_____

_____

_____

Signature of Reviewer Date of Review

****If 50% or more of the time within the encounter is spent counseling and coordination of care code based on time

E&M AUDIT FORM

Record # _____ Date Of Service _____ Provider _____

Patient Name:_____ Payer _____ Type of Service _____

HISTORY

History of Present Illness

- ☐ Location _____
- ☐ Quality _____
- ☐ Severity _____
- ☐ Duration _____
- ☐ Timing _____
- ☐ Context _____
- ☐ Mod./F _____
- ☐ Assoc. S&S _____

Review of Systems

- ☐ Const
- ☐ Eyes
- ☐ ENMT
- ☐ Cardio
- ☐ Resp
- ☐ Gastro
- ☐ Genito-u
- ☐ Skin/breast
- ☐ M/S
- ☐ Neuro
- ☐ Psych
- ☐ Endo
- ☐ Hemo/lymph
- ☐ Allergic /immune

Past Family Social History

Past Medical

☐ Allergies, Drug, Food, Updated

Family

☐ Diseases M F S _____

Social

☐ Tobacco, Alcohol, M S D W

EXP 2HS /Pub.-Private day care _____

Total HPI _____

- ☐ **Brief HPI (1-3) = PF & EPF & D**
- ☐ **Extended HPI (4+) = Comp**
- ☐ **Chronic Conditions**

1 2 3

Total ROS_____

- ☐ **All other systems reviewed & neg.**
- ☐ **Problem Pert. =(1)**
- ☐ **Extended (2-9)**
- ☐ **Complete (10+)**

Total PFS _____

- ☐ **Pert. = (1)**
- ☐ **Complete = 2 Est out pt / ER**
- ☐ **Complete=3 New /consults**
- **Initial hosp., Obs, NSG**

General Multi-System Exam

- ■ **CONSTITUTIONAL** ☐
  - General Appearance
  - 3-7 Vitals
- ■ **EYES** ☐
  - Conjunctiva, lids
  - Pupils Irises
  - Opthal exam, / glasses
- ■ **ENMT** ☐
  - ears, nose
  - septum mucosa turbinates
  - Oropharynx
  - Lips, teeth, gums
- ☐☐ **HEAD / FACE**
- ☐☐ **NECK**
  - Thyroid
- ■ **RESPIRATORY** ☐
  - Effort
  - Percussion / Auscultation
- ■ **CARDIOVASCULAR** ☐
  - Palpation
  - Auscultation / RRR
  - Periph Pulse/ Varicosities
- ☐☐ **CHEST / Breast / Axillea**
  - Breast /Axilla

- ■ **GASTROINTESTIONAL** ☐
- ☐☐ Abdomen
  - Tenderness
  - Bowel sounds
- ☐☐ Genitalia, groin,buttocks
- ■ **GENITOURINARY** ☐
- ■ **Lymph/ Hemic/Immune** ☐
  - Neck
  - axillea
  - groin
- ■ **SKIN** RU RL LU LL ☐
  - Insp/ bruising /rash
  - Incision
  - Laceration
- ■ **MUSCULOSKELETAL** ☐
  - Gait /Station
  - Palpation nails. Digits
  - Posture
  - Head Neck: Insp /palp
  - Head Neck: Motion
  - Head Neck: Stability
  - Head Neck: Strength
- ☐☐ **BACK** Spine / Rib/ Pelvis: Insp /palp C T L S
  - Spine/ Rib/ Pelvis: Motion C T L S
  - Spine /Rib / Pelvis: Stability C T L S
  - Spine / Rib / Pelvis: Strength C T L S

- ☐ R **Right Upper**
  - Right Upper Ext: Insp /palp
  - Right Upper Ext : Motion
  - Right Upper Ext : Stability
  - Right Upper Ext: Strength
- ☐ L **Left Upper**
  - Left Upper Ext: Insp /palp
  - Left Upper Ext : Motion
  - Left Upper Ext : Stability
  - Left Upper Ext: Strength
- ☐ R **Right Lower**
  - Right Lower Ext: Insp /palp
  - Right Lower Ext : Motion
  - Right Lower Ext : Stability
  - Right Lower Ext: Strength
- ☐ L **Left Lower**
  - Left Lower Ext: Insp /palp
  - Left Lower Ext : Motion
  - Left Lower Ext : Stability
  - Left Lower Ext: Strength
- ■ **NEURO** ☐
  - Sensation RU LU RL LL
  - DTR RU LU RL LL
  - Other RU LU RL LL
- ■ **PSYCHIATRIC** Mood /Affect ☐

☐☐ = Body Area ☐☐ = Organ system ☐☐ =Elements Level of Exam Component

1-5 Elements = PS	6 Elements = EPF	12 Elements = D	19 - 2 elements 9 OS	1997
1 L = PF (01-12)	2-7 L = EPF (02-13)	2-7 w/1 ext = D (03-14)	8 OS = C 04-05-15	1995

Medical Decision Making

Record # _____ Date Of Service _____ Provider _____

Patient Name:_____ Payer _____ Type of Service _____

Number of Dx / Management Options

Self Limited or minor (stable improved or worsening). Max 2 points (2 conditions)	1	A
Estab. Problem (to MD) stable or improved	1	
Estab. Problem (to MD), worsening	2	
New Problem (to MD), No additional work up is planned	3	
New Problem (to MD), Additional work up is planned	4	
Total		B

Complexity of Data Reviewed	
Lab ordered and /or reviewed regardless as to # ordered	1
X-Ray ordered and /or reviewed regardless as to # ordered	1
Medicine section ordered and /or reviewed	1
Discussion of test results with performing physician	1
Decision to obtain old records and /or obtain hx from someone OT patient	1
Review & summary old records & / or obtain hx from someone OT patient & / or discussion with other provider	2
Independent visualization of image / tracing / or specimen (not simply reviewing report)	2
Total	

Table of Risk

C	Presenting Problems	Diagnostics ordered	Management Options
Minimal	One self limited or minor problem eg. Cold, insect bite, tinea corporis	Labs / venipunture Chest x-ray EKG/ EEG Urinalysis Ultrasound Echocardiography KOH prep	Rest Gargles Elastic bandages Superficial Dressings
Low	Two or more self limited or minor problem One stable or chronic illness well controlled hypertension BPH, Acute uncomplicated illness / injury, eg cystitis, allergic, rhinitis, simple sprain	Physiologic test NOT under stress Non cardio imaging w/ contrast Superficial needle bx Labs, arterial puncture, Skin bx.	Over the counter drugs Minor surgery w/no risk Physical therapy Occupational therapy IV fluids w/o additives
Moderate	One or more chronic w/ mild exacerbation Two or more stable chronic problems, Acute illness w/ systemic Acute complicated injury Undiagnosed new problem uncertain prognosis	Physiologic test under stress cardiac stress fetal contraction stress Dx endoscopies, Deep needle / incisional bx Cardio imaging w/contrast w/o risk Obtain body fluid, lumbar puncture	Minor surgery w/identified risk Elective surgery w/o identified risk(open, percutaneous, endoscopic Prescription Drug mgt. Nuclear med IV fluids with additives Closed txmt Fx or dislocation w/out manipulation
High	One or more chronic w/severe exacerbation Acute illness poses threat to life or bodily function mult trauma, severe rheumatoid, Renal failure, TIA Seizure , Abrupt neurologic change	Cardio imaging w/contrast w/risk Cardiac electrophysiology Dx endoscopies w/ risk factors Discography	Elective Minor surg. w/risks Emergency major surgery Parenteral controlled substances Drug Therapy w/ monitoring for toxicity Decision not to resuscitate

Medical Decision Making		Straightforward	Low	Moderate	High
A	Number of Diagnoses or treatment options	1	2	3	4
B	Amount and / or Complexity of data to be reviewed	1	2	3	4
C	Risk of complications,Mobidity, Mortatility	Minimal	Low	Moderate	High
Level of MDM is based on 2 out of 3 of A,B, and /or C					

MDM _____

2

Exercise 2—Operative Report

Preliminary Report

Patient: Terry Smith

Date of Operation: 01/06/09

Preoperative Diagnosis: Locked Medial meniscal tear.

Postoperative Diagnosis: Same

Surgeon: Jeffrey Scopeman, MD

Anesthesia: General.

Indications for Procedure: The patient is a 21 year old year-old male who presents at this point in time for treatment of his left knee pain.

Interpretive Findings: Examination under anesthesia reveals a stable left knee with medial meniscal tear.

Description of Procedure: On 02/06/09, the patient was taken to the operating room. After adequate general anesthesia, the right lower extremity was prepped with alcohol, painted with Betadine, and draped in the usual sterile fashion. The tourniquet was inflated to 300 mm Hg of pressure. The arthroscope was introduced entered the medial compartment where the medial meniscus was visualized and probed. It underwent reduction followed excision. It was removed through a combination of anteromedial and anterolateral portals, through a combination of biter, shaver and punch. A final inspection of the knee revealed no_____ pathology. Therefore, attention was turned toward the closure. The knee was well irrigated with overhead solution followed by the removal of arthroscopic instrumentation with tips intact. The portal sites were closed with a simple Prolene stitch followed by injection of Marcaine 0.25% with epinephrine. _____

_____

Jeffrey Scopeman, MD

Clinical Documentation Report Review Sheet Surgical Report				
Patient Name First			Last	
Date of Birth			Acct. #	
Content	**YES**	**No**	**N/A**	**Comments**
Patient Identity on Each Page				
Facility Location Identified				
Hospital unique Identifiers				
Hospital Status				
In Patient				
Out-patient / Observation				
Date of Surgery				
Prophylactic Antibiotics				
Allergy Information				
Primary Surgeon Identified				
Assistant Surgeon Identified				
Anesthesia				
Preoperative Diagnosis				
Post-operative Diagnosis				
Procedure Title				
Informed Consent				
Indication for Procedure				
Results of Diagnostic Report				
Procedure Details				
Incidental Findings Positive or Negative				
Tissue or Organ Removed				
Application / Insertion Implants				
Implant information				
Closure Type				
Drainage Application / Type				
Wound status				
Estimated Blood Loss				
Transfusion Information				
Complications Described				
Patient's Tolerance of Procedure				
Signatures				
Legibility				
CC Notes as Applicable				
Date of Dictation and Transcription				
Reviewer's Name:			Date of Review:	

Central City
Ambulatory Surgery Center
Mid Town Station
Jackson Mississippi 31205 -3234

Exercise # 2 Coding Sheet

Patient:

MR#

DOB

Date of Operation:

Coding Sheet

Name: MD:

Service Date	CPT	Modifier	Dx 1	Dx2	Dx3	Dx4	POS	Injury Date

Exercise 3—E-Medical Record Documentation Review

What is Missing?

Jackie Smith

MR # 567003

DOB 6/1/1946

CC: Follow-up diabetes management.

Jackie comes back into the office today in follow-up for diabetes which is well controlled. She has a negative ROS. Jackie is very frustrated because of her weight gain; she as gained 25 more pounds. She state she has been on Weight Watchers and the Adkins diet and nothing has worked.

Jackie says she is so disgusted with herself she rarely leaves the house. I had a long discussion with Jackie today about her eating habits. I recommended she keep a journal of her intake for 14 days, keeping track of the item, time, and amount. I gave Jackie a nutrition plan to follow. I will see Jackie back in four weeks. This weight loss plan should promote at least a weight loss of three pounds. I spent 45 minutes with Jackie.

Impression:

Type II diabetes

Morbid Obesity

William Neil Sanchez, M.D.

Electronically Signed on 06/22/2010 3:16 pm.

Exercise 3—Improvement

Jackie Smith

MR # 567003

DOB 6/1/1946

DOS 6/22/10

CC: Follow-up diabetes management.

Height 5'6" Weight 216 BMI 36

Jackie comes back into the office today in follow-up for diabetes which is controlled with her medications. Her A1C level is 7.5 which is a slight lower that it was six months ago.

ROS:

Eyes: Negative last vision exam was in March of last year.

Neuro: Negative for any signs of neuropathy.

Urinary: As long as she takes her medication as prescribed she has not problems with frequency of urination.

PFS

Father Diabetes HTN

Mother: Parkinson's Morbid obesity

Medical: Diabetes, HTN, Hyperlipidemia

Medications: See list in chart.

Allergies: Shellfish

She can tell when her sugar is high because she becomes very fatigued. She states she has been very careful to make sure she is consistent with her medication. Jackie's major complain today is her weight. She is very frustrated because of her weight gain; she as gained 25 more pounds. She says she has been on Weight Watchers and the Adkins diet and nothing has worked. Jackie says she is so disgusted with herself she rarely leaves the house. She is retired. I had a long discussion today with Jackie; I am concerned about her depression. She needs to get out and about. She needs to increase her activity levels. She is otherwise in very good health for her age and can get around and ambulate, surprisingly well, without any difficulty.

Jackie Smith

MR # 567003

DOB 6/1/1946

DOS 6/22/10

CC: Follow-up diabetes management.

I recommended counseling with a nutritionist. She says she does not want to go to any other doctors right now she cannot afford it.

I recommended Jackie keep a journal of her intake for 14 days, keeping track of the item, time, and amount eaten. We set reasonable goals for her to follow and I discussed the importance of good nutrition. I gave Jackie a nutrition plan to follow for the next four weeks. This is a gradual weight loss plan and is more of life style changes. I believe part of her eating problem is related to her depression. I recommended an exercise plan for her. I gave her a prescription for the senior water aerobics. This is a free service at the hospital with trained therapist. I also encouraged her to make friends with the ladies there. She lives alone and has few friends. She is to continue her medication as prescribed. She understands the importance of getting her weight under control and taking her medication as prescribed. I will see her back in 4 weeks. If she is no better I will order a TSH, LFT, UA, and CBC and blood creatinine and GFR

I spent at least 45 minutes with Jackie counseling her on her weight and her activities and how her diabetes is impacted.

Impression:

Type II Diabetes

Mild Depression

Morbid Obesity

William Neil Sanchez, M.D.

Electronically Signed on 06/22/2010 3:16 pm.

Document Assessment

Record # Date Of Service _____ Provider _____

Patient Name:_____ Payer:_____

Component	New Patient Visit Each Component is Required All 3 Must Meet/or Exceed				
History	PF	EPF	D	C	C
Examination	PF	EPF	D	C	C
Medical Decision Making	SF	SF	L	M	H
Level of service	99201	99202	99203	99204	99205
Time **See below	10	20	30	45	60

Component	Established Patient Visit Two Components Are Required—2 Must Meet/or Exceed				
History	Minimal	PF	EPF	D	C
Examination	physician presence not required	PF	EPF	D	C
Medical Decision Making	Minimal	SF	L	M	H
Level of service	99211	99212	99213	99214	99215
Time **See below	5	10	15	25	40

Components

History Level _____

Examination Level _____

Medical Decision Making Level _____

Level of Visit Reported _____

Level of Visit Reviewed _____

☐ **See attached documents for detailed explanation**

Comments

_____

_____

_____

_____

Signature of Reviewer Date of Review

****If 50% or more of the time within the encounter is spent counseling and coordination of care code based on time

E&M AUDIT FORM

Record # _____ Date Of Service _____ Provider _____

Patient Name:_____ Payer _____ Type of Service _____

HISTORY

History of Present Illness

- ☐ Location
- ☐ Quality
- ☐ Severity
- ☐ Duration
- ☐ Timing
- ☐ Context
- ☐ Mod./F
- ☐ Assoc. S&S

Review of Systems

- ☐ Const
- ☐ Eyes
- ☐ ENMT
- ☐ Cardio
- ☐ Resp
- ☐ Gastro
- ☐ Genito-u
- ☐ Skin/breast
- ☐ M/S
- ☐ Neuro
- ☐ Psych
- ☐ Endo
- ☐ Hemo/lymph
- ☐ Allergic /immune

Past Family Social History

Past Medical

☐ Allergies, Drug, Food, Updated

Family

☐ Diseases M F S _____

Social

☐ Tobacco, Alcohol, M S D W

EXP 2HS /Pub.-Private day care

_____

Total HPI _____

- ☐ **Brief HPI (1-3) = PF & EPF & D**
- ☐ **Extended HPI (4+) = Comp**
- ☐ **Chronic Conditions**

1 2 3

Total ROS _____

- ☐ **All other systems reviewed & neg.**
- ☐ **Problem Pert. =(1)**
- ☐ **Extended (2-9)**
- ☐ **Complete (10+)**

Total PFS _____

- ☐ **Pert. = (1)**
- ☐ **Complete = 2 Est out pt / ER**
- ☐ **Complete=3 New /consults Initial hosp., Obs, NSG**

General Multi-System Exam

- ■ **CONSTITUTIONAL** ☐
  - General Appearance
  - 3-7 Vitals
- ■ **EYES** ☐
  - Conjunctiva, lids
  - Pupils Irises
  - Opthal exam, / glasses
- ■ **ENMT** ☐
  - ears, nose
  - septum mucosa turbinates
  - Oropharynx
  - Lips, teeth, gums
- **HEAD / FACE**
- **NECK**
  - Thyroid
- ■ **RESPIRATORY** ☐
  - Effort
  - Percussion / Auscultation
- ■ **CARDIOVASCULAR** ☐
  - Palpation
  - Auscultation / RRR
  - Periph Pulse/ Varicosities
- **CHEST / Breast / Axillea**
  - Breast /Axilla

- ■ **GASTROINTESTIONAL** ☐
  - Abdomen
  - Tenderness
  - Bowel sounds
  - Genitalia, groin,buttocks
- ■ **GENITOURINARY** ☐
- ■ **Lymph/ Hemic/Immune** ☐
  - Neck
  - axillea
  - groin
- ■ **SKIN** RU RL LU LL ☐
  - Insp/ bruising /rash
  - Incision
  - Laceration
- ■ **MUSCULOSKELETAL** ☐
  - Gait /Station
  - Palpation nails. Digits
  - Posture
  - Head Neck: Insp /palp
  - Head Neck: Motion
  - Head Neck: Stability
  - Head Neck: Strength
  - **BACK** Spine / Rib/ Pelvis: Insp /palp C T L S
  - Spine/ Rib/ Pelvis: Motion C T L S
  - Spine /Rib / Pelvis: Stability C T L S
  - Spine / Rib / Pelvis: Strength C T L S

- R **Right Upper**
  - Right Upper Ext: Insp /palp
  - Right Upper Ext : Motion
  - Right Upper Ext : Stability
  - Right Upper Ext: Strength
- L **Left Upper**
  - Left Upper Ext: Insp /palp
  - Left Upper Ext : Motion
  - Left Upper Ext : Stability
  - Left Upper Ext: Strength
- R **Right Lower**
  - Right Lower Ext: Insp /palp
  - Right Lower Ext : Motion
  - Right Lower Ext : Stability
  - Right Lower Ext: Strength
- L **Left Lower**
  - Left Lower Ext: Insp /palp
  - Left Lower Ext : Motion
  - Left Lower Ext : Stability
  - Left Lower Ext: Strength
- ■ **NEURO** ☐
  - Sensation RU LU RL LL
  - DTR RU LU RL LL
  - Other RU LU RL LL
- ■ **PSYCHIATRIC** Mood /Affect ☐

☐☐ = Body Area ☐☐ = Organ system ☐☐ =Elements Level of Exam Component

1-5 Elements = PS	6 Elements = EPF	12 Elements = D	19 - 2 elements 9 OS	1997
1 L = PF (01-12)	2-7 L = EPF (02-13)	2-7 w/1 ext = D (03-14)	8 OS = C 04-05-15	1995

Medical Decision Making

Record # _____ Date Of Service _____ Provider _____

Patient Name:_____ Payer _____ Type of Service _____

Number of Dx / Management Options

Self Limited or minor (stable improved or worsening). Max 2 points (2 conditions)	1	A
Estab. Problem (to MD) stable or improved	1	
Estab. Problem (to MD), worsening	2	
New Problem (to MD), No additional work up is planned	3	
New Problem (to MD), Additional work up is planned	4	
Total		B

Complexity of Data Reviewed	
Lab ordered and /or reviewed regardless as to # ordered	1
X-Ray ordered and /or reviewed regardless as to # ordered	1
Medicine section ordered and /or reviewed	1
Discussion of test results with performing physician	1
Decision to obtain old records and /or obtain hx from someone OT patient	1
Review & summary old records & / or obtain hx from someone OT patient & / or discussion with other provider	2
Independent visualization of image / tracing / or specimen (not simply reviewing report)	2
Total	

Table of Risk

C	Presenting Problems	Diagnostics ordered	Management Options
Minimal	One self limited or minor problem eg. Cold, insect bite, tinea corporis	Labs / venipunture Chest x-ray EKG/ EEG Urinalysis Ultrasound Echocardiography KOH prep	Rest Gargles Elastic bandages Superficial Dressings
Low	Two or more self limited or minor problem One stable or chronic illness well controlled hypertension BPH, Acute uncomplicated illness / injury, eg cystitis, allergic, rhinitis, simple sprain	Physiologic test NOT under stress Non cardio imaging w/ contrast Superficial needle bx Labs, arterial puncture, Skin bx.	Over the counter drugs Minor surgery w/no risk Physical therapy Occupational therapy IV fluids w/o additives
Moderate	One or more chronic w/ mild exacerbation Two or more stable chronic problems, Acute illness w/ systemic Acute complicated injury Undiagnosed new problem uncertain prognosis	Physiologic test under stress cardiac stress fetal contraction stress Dx endoscopies, Deep needle / incisional bx Cardio imaging w/contrast w/o risk Obtain body fluid, lumbar puncture	Minor surgery w/identified risk Elective surgery w/o identified risk(open, percutaneous, endoscopic Prescription Drug mgt. Nuclear med IV fluids with additives Closed txmt Fx or dislocation w/out manipulation
High	One or more chronic w/severe exacerbation Acute illness poses threat to life or bodily function mult trauma, severe rheumatoid, Renal failure, TIA Seizure , Abrupt neurologic change	Cardio imaging w/contrast w/risk Cardiac electrophysiology Dx endoscopies w/ risk factors Discography	Elective Minor surg. w/risks Emergency major surgery Parenteral controlled substances Drug Therapy w/ monitoring for toxicity Decision not to resuscitate

Medical Decision Making		Straightforward	Low	Moderate	High
A	Number of Diagnoses or treatment options	1	2	3	4
B	Amount and / or Complexity of data to be reviewed	1	2	3	4
C	Risk of complications,Mobidity, Mortatility	Minimal	Low	Moderate	High
Level of MDM is based on 2 out of 3 of A,B, and /or C					

MDM _____

Exercise 4—Evaluation and Management

Date of Exam: September 1, 2011

Provider: Charles H. Sims, MD

Provider NPI: 89797979792

Patient Name: John Rogers

Date of Birth: 3-17-53

Chief Complaint: Low Blood Pressure

Mr. Rogers comes in today, he is well known to this practice. He is coming in for a new problem today. He is complaining of "Low Blood Pressure". He is an employee of the state highway commission of Idaho. Blood pressure machines are in the fitness gym provided to the employees by the state. He has taken his BP several times over the past 3 days reporting this as staying around 100/65. He feels tired, and has no energy. He has lost 15 lbs. just recently. He is 6'6" and weights 325 lbs. He is in great physical shape even though he is obese. He gets short of breath when he exerts himself lifting or moving heavy objects. John is very concerned that his cardiologist would not see him for three weeks. He was told to go to the emergency room if he felt like he was going to pass out. He has not felt like he is about to pass out. He is very upset and very anxious about his BP because of his history with having and ICD implanted 3 years ago.

MEDICAL HISTORY: Insertion ICD 3 years ago, appendectomy, history of kidney stones. Type II Diabetes Mellitus.

FAMILY HISTORY: Uncle and Grandfather are deceased both due to colon cancer

SOCIAL HISTORY: Married, does not smoke, occasionally drinks socially.

ALLERGIES: Negative; He does report to have seasonal environmental allergies.

OTHER: Latex

MEDICATION: See comprehensive medication list in the chart this list was updated today with the changes made during this visit.

John takes his medication as prescribed.

1

Date of Exam: September 1, 2011

Provider: Charles H. Sims, MD

Provider NPI: 89797979792

Patient Name: John Rogers

Date of Birth: 3-17-53

ROS: He has no complaints with shortness of breath, headaches, dizziness, nausea, vomiting. He does complain as stated above with generalized weakness and dyspena on exertion. He denies pain with urination. He denies back pain or flank pain.

EXAM:

CONSTITUTION: Well nourished male, appears to be in good health.

BP @ 10:20am 96/66 **Resp.** 24 **BP @** 11:00 **am** 100/70 **Temp:** 98.6 **BMI** 37.7

ENMT: Normal

EYES: RERRLA

HEART: RRR, Capillary refill < 3 seconds.

NECK: Normal supple no masses, no lymphadenopathy.

RESPIRATORY: Clear to auscultation

GASTROINTESTINAL: Non-tender - normal bowel sounds in all quadrants. No organmegaly.

PSYCHOLOGICAL: John is extremely nervous and anxious today. This is more episodic in nature he is a very nice gentleman were well adjusted with no history of physiological problems. The drastic change in his blood pressure has heightened his concern.

Exam Documentation

DIAGNOSIS: Low blood pressure, generalized weakness, dyspena on exertion, unexplained weight loss.

Date of Exam: September 1, 2011

Provider: Charles H. Sims, MD

Provider NPI: 89797979792

Patient Name: John Rogers

Date of Birth: 3-17-53

PLAN: CBC, A1C, Stool culture

Adjust his Lisinopril to 30.mg daily instead of 40mg. daily
Discontinue Lasix

I believe John's recent change in BP is the result of his sudden weight loss. He is instructed to call immediately if he has any problems with a drastic increase in pressure. He is to monitor his pressure closely. I discontinued his Lasix. John has no history of edema or lower extremity swelling. I am not quite sure why this was prescribed. I will call Dr. Carbain and inquire about the Lasix. I will let John know if Dr. Carbain disagrees with my discontinuing this based on his history. John understood this and the instructions / precautions. He seemed to be less anxious. Discussing his symptoms and his medications and the impact of his recent weight loss seemed to relieve him somewhat. He is also relieved that we will check on him in one week. He will see me again next Tuesday.

Charles Sims, M.D.
Electronically Signed September 1, 2011

Charles H. Sims, M.D.
Family Practice
7937 Hospital Blvd. East
Cunningham, Idaho 23556
547-793-7937

Exercise # 4 Coding Sheet

Patient: _____

MR#

DOB

Date

Name: MD:

Service Date	CPT	Modifier	Dx 1	Dx2	Dx3	Dx4	POS	Injury Date

Exercise 5—Operative Reports

Patient Name: John Rogers

DOB: 3-17-1953

Date of service: September 7, 2011

Provider: Richard Jones, M.D.

Assistant Surgeon:

Anesthesia: 6 mg of Versed

Preoperative: Anemia

Postoperative Diagnosis

Procedure Performed: Diagnostic colonoscopy

Indications for procedure: The patient presented to the office of his PCP Dr, Charles Sims, complaining of low blood pressure. Dr. Sims adjusted his blood pressure medication and after running blood work he was diagnosed as being anemic. Due to his current anemia, and he felt this patient should undergo another diagnostic colonoscopy.

PROCEDURE

With the Jason in the left lateral_____and after sedation using 6 mg of Versed and 100 mcg of Fentanyl, the Olympus adult colonoscope was inserted and advanced to the cecum. The ileocecal _____valve and appendiceal openings _____ normal. The scope was withdrawn with the viewing circumferentially the cecum, right colon, hepatic flexure, transverse colon, splenic flexure, _____left colon, and sigmoid. Diverticular opening noted. In the distal rectum there were multiple irregular lesions I performed a biopsy on each of these lesions.

I will see Mr. Rogers in the office in three days to discuss his path report.

Richard Jones, M.D.

Electronically signed, 9-18-11

Clinical Documentation Report Review Sheet Surgical Report				
Patient Name First			Last	
Date of Birth			Acct. #	
Content	**YES**	**No**	**N/A**	**Comments**
Patient Identity on Each Page				
Facility Location Identified				
Hospital unique Identifiers				
Hospital Status				
In Patient				
Out-patient / Observation				
Date of Surgery				
Prophylactic Antibiotics				
Allergy Information				
Primary Surgeon Identified				
Assistant Surgeon Identified				
Anesthesia				
Preoperative Diagnosis				
Post-operative Diagnosis				
Procedure Title				
Informed Consent				
Indication for Procedure				
Results of Diagnostic Report				
Procedure Details				
Incidental Findings Positive or Negative				
Tissue or Organ Removed				
Application / Insertion Implants				
Implant information				
Closure Type				
Drainage Application / Type				
Wound status				
Estimated Blood Loss				
Transfusion Information				
Complications Described				
Patient's Tolerance of Procedure				
Signatures				
Legibility				
CC Notes as Applicable				
Date of Dictation and Transcription				
Reviewer's Name:			Date of Review:	

High City Hospital
207688 Hospital Drive
Cunningham Idaho, 23556

Medical Record # 00997696500
Status Out Patient Same Day Unit

Exercise # 5 Coding Sheet

Patient: _____

MR#

DOB

Date

Name: MD:

Service Date	CPT	Modifier	Dx 1	Dx2	Dx3	Dx4	POS	Injury Date

Exercise # 1	**Clinical Documentation Evaluation and Management Review**		
NAME	Yes	No	Comments
First Jessica	X		Ea. Page Yes ___ No_X__
Last Hughes	X		Ea. Page Yes ___ No_X__
Middle		X	Ea. Page Yes ___ No___
Date of Service	X		9/26/2011
Date of Birth	X		6/16/1950
Practice Name / Identifiers		X	
Allergy "Current"			The note populated: BACTRIMDS microdantinmicrodantinmicrodantin. This is run together and repeated three times. It is evident no one looked at this document before signing off. The ROS contradicts the note. Also indication this was populated with incorrect negatives.
Current Problem list		X	
Chronic Conditions		X	None Listed: Diabetes and Osteoporosis should be listed as positive or negative due to age and the fact that this "could be" a stress fracture.
Medication list	X		Only Estrogen listed
Renewal Hx. HX ROS PFS	X		Why so detailed for follow-up
Physician Notes:	X		Even in the HPI a reviewer cannot determine the "reason for the encounter"
Exam / Clinical findings	X		Looks copied /too comprehensive
Chief Complaint			See previous ? ? No meaning
Preventive information Hx. if PCP			Screening for Osteoporosis ???? Was this done previously or recommended as the result of this fracture?
Immunizations if applicable		N/A	
ROS Positive and Negative ***(This note looks as though someone other than the MD reviewed this data and populated the record.)***		X	Copied from previous note. See Allergies as stated above. See Cardiovascular ROS. Is the an error where the word "No" was missed or does the patient have chest pains, palpitations, and high blood pressure.

Exercise # 1	**Clinical Documentation Evaluation and Management Review**		
Major health risks		X	None mentioned The patient is 62yrs old. It is unusual that her medical history would be so generic. No medial history reported and no surgical history reported is questionable given the age of this patient. Additionally in the "Allergy" list was antibiotic commonly used with frequent UTI
Prior unresolved /current conditions		X	None mentioned
Patient compliance and response to treatment			Only note is "doing better" in the HPI
Provider Plan of Care	X		Brief
Patient Education		X	Not documented
Follow-up Instructions	X		Return in two weeks
Evidence of patient understandings instructions		X	No evidence
Rx. w/ name /dose /instructions		X	Previously prescribed name not mentioned
Physician Signature		X	
Physician typed or printed name.		X	Not typed no proof of author
Counter -Signature			N/A
Tests results /initialed / acknowledged	X		X-ray report and findings
Evidence patient was notified of results			No evidence results were discussed with patient
Signature or acknowledgement in the note of the review of medical intake forms completed by patient		X	This is a follow-up visit. The provider could have updated her history and if no change, noted that he questioned the patient concerning an interim history and there were no changes since her visit on 9/10/2011
Evidence of coordination of care.		X	
Medical necessity for orders on specified plan of care	X		
Notation of follow-up / PRN /D/C	X		
Diagnosis for current encounter	X		
Co-Morbidities impacting care/ outcome		X	
Documentation completed same date of encounter		X	
Coded services documented		X	It is evident that most of the documentation is copied from a previous note. Medical necessity for the charges are questionable

Electronic : _____X_____ Hard Copy _____

Comments: X-ray charges are supported with the documentation . Medication previously provided should be mention. Osteoporosis could impact txmt and plan. Patient is 62 years old. The mechanism of injury is not dictated no is the date of injury brought forward. This makes one question is there a possibility of a stress fracture? The patient is in a global txmt for a fracture. The visit is a no charge visit. There is no need for the documentation to be this comprehensive for the ROS and the exam. This is considered "Fluff" The needed information such as co conditions that may be the cause of slow healing is not documented. Evidence that the condition is related to an injury or a stress fracture should be in every follow-up note. The document looks electronically generated without evidence of "current" patient condition and care. The fact that there are obvious error in this note. The integrity of the note is lost.

Date Reviewed: Reviewed By:

Exercise # 2	**Clinical Documentation Report Review Sheet**			
	Surgical Report			
Patient Name First Terry			Last Smith	
Date of Birth 2-11-1981			Acct. # 325678	
Content	**YES**	**No**	**N/A**	**Comments**
Patient Identity on Each Page		X		Patient not identified on 2nd pg
Facility Location Identified	X			
Hospital unique Identifiers	X			
Hospital Status			N/A	ASC Facility
In Patient			N/A	
Out-patient / Observation			N/A	
Date of Surgery	X			
Prophylactic Antibiotics		X		
Allergy Information		X		
Primary Surgeon Identified	X			
Assistant Surgeon Identified	X			
Anesthesia	X			
Preoperative Diagnosis	X			
Post-operative Diagnosis	X			
Procedure Title	X			
Informed Consent		X		No evidence of consent
Indication for Procedure	X			
Results of Diagnostic Report		X		
Procedure Details	X			
Incidental Findings Positive or Negative	X			
Tissue or Organ Removed		X		
Application / Insertion Implants			N/A	
Implant information			N/A	
Closure Type	X			
Drainage Application / Type		X		
Wound status	X			
Estimated Blood Loss	X			
Transfusion Information			N/A	
Complications Described	X	X		
Patient's Tolerance of Procedure	X			
Signatures	X			
Legibility	X			
CC Notes as Applicable			N/A	
Date of Dictation and Transcription	X			Not date of transcription
Reviewer's Name:			Date of Review:	

Example 2 Lacks Information

_____

Preliminary Report

Patient: Terry Smith

_____

Date of Operation: 01/06/09

Preoperative Diagnosis: Locked Medial meniscal tear.

Postoperative Diagnosis: **Same**

Surgeon: Jeffrey Scopeman, MD

Anesthesia: General.

_____

Indications for Procedure: The patient is a 21 year old year-old male who presents at this point in time for treatment of his left knee pain.

Interpretive Findings: Examination under anesthesia reveals a stable left knee with medial meniscal tear.

Description of Procedure: On 02/06/09, the patient was taken to the operating room. After adequate general anesthesia, the right lower extremity was prepped with alcohol, painted with Betadine, and draped in the usual sterile fashion. The tourniquet was inflated to 300 mm Hg of pressure. The arthroscope was introduced entered the medial compartment where the medial meniscus was visualized and probed. It underwent reduction followed excision. It was removed through a combination of anteromedial and anterolateral portals, through a combination of biter, shaver and punch. A final inspection of the knee revealed no_____ pathology. Therefore, attention was turned toward the closure. The knee was well irrigated with overhead solution followed by the removal of arthroscopic instrumentation with tips intact. The portal sites were closed with a simple Prolene stitch followed by injection of Marcaine 0.25% with epinephrine. _____

_____

Jeffrey Scopeman, MD

Comment [O1]: Facility is missing

Comment [O2]: This report is a preliminary report and should not be the source of coding or appealing. The provider has not signed off on this record.

Comment [O3]: What is missing here is additional patient Identification information. The date of birth should be documented on each patient document or a unique identification number,

Comment [O4]: The body of the report stated the meniscus was "reduced" then excised. This can be indicative of a bucket handle tear which will flip over into the joint and "lock" the knee. More detail should be provided.

Comment [O5]: The procedure performed is not documented

Comment [O6]: It is unusual for a 21 year old to have a degenerative tear of the meniscus. This indicates the provider may have failed to report the mechanism of injury. And the circumstances of injury. Is this a third party liability case. A work related case, auto, or sports related. A CDS would need to query the provider for these details. The indications for surgery supports the need. This is very vague and lacks support for surgical treatment.

Comment [O7]: Incorrect date

Comment [O8]: Should be left knee

Comment [O9]: Detail is lacking for "procedure"

Comment [O10]: This is a gap in the dictation. If the provider fails to correct this, even though this is a simple fix the report make the provider look careless. Particularly if this turns into a "legal" case

Comment [O11]: What is missing here is the condition of the patient immediately following the procedure. Not documenting the condition of the patient at this stage may put the provider at risk if the patient experiences any type complication in the recovery room.

Comment [O12]: The report is not authenticated.

Example 2 Same report with documentation improvement

Central City
Ambulatory Surgery Center
Mid Town Station
Jackson Mississippi 31205 -3234

Comment [O13]: Name of facility. Also indicates Place of service should be 24

Patient: Terry Smith

MR# 325679

Comment [O14]: ASC Patient ID #

DOB 2/11/1981

Comment [O15]: Date of birth additional patient identity

Date of Operation: 01/06/09

Preoperative Diagnosis: Left knee medial meniscal tear.

Postoperative Diagnosis: Left knee locked **bucket-handle** medial meniscal tear.

Comment [O16]: Better detail with the documentation of the postoperative di.

Operation Performed: Left knee

1. Exam under anesthesia.
2. Video arthroscopy.
3. Partial medial meniscectomy

Comment [O17]: Procedure performed is a quick reference. The body of the operative report should report details of each. Item # 2 indicates the chart should have copies of images of the procedure.

Surgeon: Jeffrey Scopeman, M.D.

Anesthesia: General.

Indications for Procedure: The patient is a 19-year-old male who presents at this point in time for treatment of his left knee on which he has been having problems and it is hindering while playing basketball. He has had intermittent locking of the knee and intermittent catching of the knee. On Jan 3rd he was playing basketball and twisted his knee and locked it. He has developed swelling and medial side pain. Secondary to this he is brought to the operating room at this time for treatment.

Comment [O18]: Details and date of injury

Interpretive Findings: Exam reveals a stable knee under examination under anesthesia. The video arthroscopy examination reveals smooth articular surfaces throughout the entire knee. He has a lateral meniscus which is normal. His medial meniscus shows a locked bucket-handle medial meniscal tear which underwent excision. The cruciate ligament is intact.

Comment [O19]: More descriptive severity and type of the meniscal tear.

Comment [O20]: Additional negative findings assist with future problems or complaints. This type documentation adds details to the patients clinical condition which is useful if the patient presents with additional complaints. Confirmed negative findings are just as important as the positive findings better demonstrate the patients true clinical condition on this date of service.

Description of Procedure: On 021/06/09, the patient was taken to the operating room. After adequate general anesthesia, the left lower extremity was prepped with alcohol, painted with Betadine, and draped in a sterile fashion.
The tourniquet was inflated to 300 mm Hg of pressure. The arthroscope was introduced through the anteromedial portal with visualization of the patellofemoral joint, negative. The medial compartment

Comment [O21]: See comment 014

was entered where the medial meniscus was visualized and probed. It was a locked bucket-handle medial meniscal tear noted with a rim remaining with some tearing. It underwent reduction followed excision. It was removed through a combination of anteromedial and anterolateral portals, through a combination of biter, shaver and punch. Once the fragment had been removed, the remaining rim was trimmed of its remaining fragments with the shaver. The medial femoral condyle was smooth as was the medial tibial plateau. Intercondylar notch area revealed intact cruciate ligament. The lateral compartment revealed a normal-appearing lateral meniscus and chondral surfaces. At this time then, a final inspection of the knee revealed no additional pathology. Therefore, attention was turned toward the closure. The knee was well irrigated with overhead solution followed by the removal of arthroscopic instrumentation with tips intact. The portal sites were closed with a simple Prolene stitch followed by injection of Marcaine 0.25% with epinephrine. The patient was extubated without any complications was transferred to the recovery room cart and taken to the recovery room in satisfactory condition having tolerated the procedure well.

Comment [O22]: Better documentation indicating techniques and details of the procedure

Comment [O23]: See comment 014

Comment [O24]: Demonstrates there were no complications with anesthesia or the procedure and was in stable / good condition when taken to the recovery room. This demonstrates standard / quality of care and protects providers if complications present in the recovery room

Jeffrey Scopeman, M.D.

Electronically signed by Dr. Jeffrey Scopeman 01/07/2009

Comment [O25]: MD Authentication of the report.

Dictated by Dr. Jeffrey Scopeman 01/06/2009

Central City
Ambulatory Surgery Center
Mid Town Station
Jackson Mississippi 31205 -3234

Patient: Terry Smith

MR# 325679

DOB 2/11/1981

Date of Operation: 01/06/09

Coding Sheet

Name: Terry Smith Dr. Jeffrey Scopeman

Service Date	CPT	Modifier	Dx 1	Dx2	Dx3	Dx4	POS	Injury Date
1-6-09	29881	LT	836.0	E007.6			24	1-3-09
	Arthroscopy with medial meniscectomy	LEFT KNEE	Acute Tear Medial Meniscus Bucket Handle	Injury Playing Basketball			Place of service is Ambulatory Surgery Center	Date of injury is 1-3-09

Exercise # 3 Answers /Discussion Clinical Documentation Evaluation and Management Review			
NAME	**Yes**	**No**	Comments
First JACKIE	**X**		Ea. Page Yes X No
Last SMITH	**X**		Ea. Page Yes X No
Middle		**X**	Ea. Page Yes ___ No___
Date of Service	**X**		
Date of Birth	**X**		6/1/1946
Practice Name / Identifiers		**X**	
Allergy "Current"	**X**		Shellfish
Current Problem list	**X**		Within the record
Chronic Conditions	**X**		HTN, Type II diabetes, hyperlipidemia
Medication list	**X**		In Chart / Should state reviewed today there are no changes.
Physician Notes:	**X**		Patient Centered.
Exam / Clinical findings	**X**		Specific to Current Condition
Chief Complaint	**X**		
Preventive information Hx. if PCP		**X**	
Immunizations if applicable		**N/A**	
ROS Positive and Negative	**X**		Specific to the condition
Major health risks		**X**	Notes ref depression and need for professional counseling.
Prior unresolved /current conditions		**X**	
Patient compliance and response to treatment	**X**		Takes her medication as directed
Provider Plan of Care	**X**		Well demonstrated
Patient Education	**X**		
Follow-up Instructions	**X**		
Evidence of patient understandings instructions	**X**		
Rx. w/ name /dose /instructions		**X**	Previously prescribed name not mentioned
Physician Signature	**X**		Electronically signed/Dated
Physician typed or printed name.	**X**		
Counter -Signature			N/A
Tests results /initialed / acknowledged	**X**		A1C
Evidence patient was notified of results	**X**		In the record

Signature or acknowledgement in the note of the review of medical intake forms completed by patient		**X**	Medication list . This should be reviewed and the MD make mention of any changes if any or that there were no changes.
Evidence of coordination of care.	**X**		Recommendations are documented even though she did not accept them
Medical necessity for orders on specified plan of care			N/A
Notation of follow-up / PRN /D/C	**X**		
Diagnosis for current encounter	**X**		
Co-Morbidities impacting care/ outcome	**X**		
Documentation completed same date of encounter	**X**		See date and time of documentation and signature. It is evident the MD documented either during or shortly after her appointment
Coded services documented	**X**		The time spent counseling and the details involved are clearly documented.

Electronic : _____X_____ Hard Copy _____

Comments:

Code by time 99215

Date Reviewed: Reviewed By:

Example #3 Exercise

The Patient Centered Record

Instructions:
Review / dissect the completed note on Jackie Smith; associate the content to the following elements

Patient Centered

Concise

Complete

Concurrent

Comprehensive

Example #3 Example Answers / Discussion

The patient Centered Record

Patient Centered

- Goes into detail about her frustration, depression
- Encourages her to get out of the house
- Encourages increase in activities
- RX for Free water aerobics
- Recommends referral for counseling (Had she accepted referrals this would represent concurrent care as well)
- Cautioned patient on the impact of her weight on her systemic diseases

Concise

- Listing A1C test results
- Specifically stating 25 lbs. instead of "recent weight gain" or other "generic" term
- List specific tests he plans to order on follow-up if there are no changes

Complete

- Jackie Smith is extremely common name.
- DOB and MR # is listed on all pages
- Listed BMI (not just height Weight)
- Nothing is missing or gapped within the note
- Again, listed family hx to demonstrate, obesity and diabetes are family history
- Impression: Dx with Depression /obesity /Type II diabetes (Many notes do not list the final impression. Coders have to abstract)

Concurrent

- Compared A1C from previous test

Comprehensive

- On ROS listed the last eye exam not just stating negative
- Again, listed family hx to demonstrate, obesity and diabetes are family history
- Mentions her personal living conditions, retired and lives alone
- Documents the extent of the weight loss program and exercise recommendation
- This note is comprehensive enough to fall within the guidelines for Preventive Counseling for Obesity
- (Another subject entirely but one can see the possibilities of a separate classification of coding if in fact the internist wanted to pursue)

Exercise #3 Discussion Time and the "Patient Centered Note"

30.6 - Evaluation and Management Service Codes - General (Codes 99201 - 99499)

C. Selection of Level of Evaluation and Management Service Based On Duration Of Coordination of Care and/or Counseling

Advise physicians that when counseling and/or coordination of care dominates (more than 50 percent) the face-to-face physician/patient encounter or the floor time (in the case of inpatient services), time is the key or controlling factor in selecting the level of service. In general, to bill an E/M code, the physician must complete at least 2 out of 3 criteria applicable to the type/level of service provided. However, the physician may document time spent with the patient in conjunction with the medical decision-making involved and a description of the coordination of care or counseling provided. Documentation must be in sufficient detail to support the claim.

EXAMPLE: A cancer patient has had all preliminary studies completed and a medical decision to implement chemotherapy. At an office visit the physician discusses the treatment options and subsequent lifestyle effects of treatment the patient may encounter or is experiencing. The physician need not complete a history and physical examination in order to select the level of service. The time spent in counseling/coordination of care and medical decision-making will determine the level of service billed.

Compliant Concise Patient Centered

- Height, weight and BMI are recorded Diagnoses for BMI should be recorded
- Performs ROS pertinent for condition

Exercise #4	**Clinical Documentation Evaluation and Management Review**		**Rationale**
	Yes	No	Comments
First Name: JOHN	X		Ea. Page Yes __X__ No___
Last Name: ROGERS	X		Ea. Page Yes __X__ No___
Middle		X	Ea. Page Yes ___ No___
Date of Service	X		9/1/2011
Date of Birth	X		3/17/1953
Practice Name / Identifiers	X		
Allergy "Current"	X		Date: Sept. 1, 2011
Current Problem list		X	N/A
Chronic Conditions		X	N/A
Medication list	X		
Renewal Hx.	X		
Physician Notes:	X		
Exam / Clinical findings	X		
Chief Complaint	X		
Preventive information Hx. If PCP	X		
Immunizations if applicable			N/A
ROS Positive and Negative	X		
Major health risks	X		
Prior unresolved /current conditions	X		
Patient compliance and response to treatment	X		
Provider Plan of Care	X		
Patient Education	X		
Follow-up Instructions	X		
Evidence of patient understandings instructions	X		
Rx. w/ name /dose /instructions	X		
Physician Signature	X		Electronically signed
Physician typed or printed name.	X		
Counter -Signature			N/A
Tests results /initialed / acknowledged		X	
Evidence patient was notified of results			N/A
Signature or acknowledgement in the note of the review medical intake forms completed by patient.			N/A
Evidence of coordination of care.	X		
Medical necessity for orders on specified plan of care	X		
Notation of follow-up / PRN /D/C	X		
Diagnosis for current encounter	X		
Co-Morbidities impacting care/ outcome		X	
Documentation completed same date of encounter	X		
Coded services documented	X		
Electronic : ___XX_____ Hard Copy _____ Comments: ICD-9-CM 796.3 Low BP NOS, 780.79 Gen. Weakness, 766.09 Dyspnea other			
CPT 99214			
Lab CBC - AlC			

Charles H. Sims, M.D.
Family Practice
7937 Hospital Blvd. East
Cunningham, Idaho 23556
547-793-7937

Exercise #4 Documentation Rationales

Date of Exam: September 1, 2011

Provider: Charles H. Sims, MD

Provider NPI: 89797979792

Patient Name: John Rogers

MR# 352369

Date of Birth: 3-17-53

Chief Complaint: Low Blood Pressure

Mr. Rogers comes in today, he is well known to this practice. He is coming in for a new problem today. He is complaining of "Low Blood Pressure". He is an employee of the state highway commission of Idaho. Blood pressure machines are in the fitness gym provided to the employees by the state. He has taken his BP several times over the past 3 days reporting this as staying around 100/65. He feels tired, and has no energy. He has lost 15 lbs. just recently. He is 6'6" and weights 325 lbs. He is in great physical shape even though he is obese. He gets short of breath when he exerts himself lifting or moving heavy objects. John is very concerned that his cardiologist would not see him for three weeks. He was told to go to the emergency room if he felt like he was going to pass out. He has not felt like he is about to pass out. He is very upset and very anxious about his BP because of his history with having and ICD implanted 3 years ago.

MEDICAL HISTORY: Insertion ICD 3 years ago, appendectomy, history of kidney stones. Type II Diabetes Mellitus. _____

FAMILY HISTORY: Uncle and Grandfather are deceased both due to colon cancer

SOCIAL HISTORY: Married, does not smoke, occasionally drinks socially.

ALLERGIES: Negative; He does report to have seasonal environmental allergies.

OTHER: Latex

Comment [U1]: Established patient new problem **Diagnosis Management**

Comment [U2]: Chief complaint and Location

Comment [U3]: **Social HX Works for state** highway

Comment [U4]: 1 HPI Severity degree of decrease

Comment [U5]: 2 HPI Signs and symptoms

Comment [U6]: 3 HPI Context

Comment [U7]: 4 HPI Modifying Factors

Comment [U8]: **Medical history**

Comment [U9]: **PAST FAMILY AND SX HX**

1

Date of Exam: September 1, 2011

Provider: Charles H. Sims, MD

Provider NPI: 89797979792

Patient Name: John Rogers

MR# 352369

MEDICATION: See comprehensive medication list in the chart this list was updated today with the changes made during this visit.

John takes his medication as prescribed.

Date of Exam: September 1, 2011

Provider: Charles H. Sims, MD

Provider NPI: 89797979792

Patient Name: John Rogers

Date of Birth: 3-17-53

ROS: He has no complaints with shortness of breath, headaches, dizziness, nausea, vomiting. He does complain as stated above with generalized weakness and dyspena on exertion. He denies pain with urination. He denies back pain or flank pain.

_____

EXAM:

CONSTITUTION: Well nourished male, appears to be in good health.

BP @ 10:20am 96/66 **Resp.** 24 **BP @** 11:00 **am** 100/70 **Temp:** 98.6 **BMI** 37.7

ENMT: Normal

EYES: PERRLA

HEART: RRR, Capillary refill < 3 seconds.

NECK: Normal supple no masses, no lymphadenopathy

2

Comment [U10]: Respiratory ROS

Comment [U11]: Neuro ROS

Comment [U12]: GI ROS

Comment [U13]: Const. ROS

Comment [U14]: Respiratory (see U1)

Comment [U15]: Urinary ROS

Comment [U16]: M/S

Comment [U17]: *ROS = Detailed 2-9*

Date of Exam: September 1, 2011

Provider: Charles H. Sims, MD

Provider NPI: 89797979792

Patient Name: John Rogers

MR# 352369

RESPIRATORY: Clear to auscultation

GASTROINTESTINAL: Non-tender - normal bowel sounds in all quadrants. No organmegaly.

PSYCHOLOGICAL: John is extremely nervous and anxious today. This is more episodic in nature he is a very nice gentleman were well adjusted with no history of physiological problems. The drastic change in his blood pressure has heightened his concern.

Exam Documentation

Comment [U18]: ***Exam documentation 8 organ systems = Comprehensive 1995***

DIAGNOSIS: Low blood pressure, generalized weakness, dyspena on exertion, unexplained weight loss.

PLAN: CBC, A1C, Stool culture

Comment [U19]: Lab orders **(WORK)**

Adjust his Lisinopril to 30.mg daily instead of 40mg. daily
Discontinue Lasix

Comment [U20]: Review of medication and change /discontinue **(RISK)**

I believe John's recent change in BP is the result of his sudden weight loss. He is instructed to call immediately if he has any problems with a drastic increase in pressure. He is to monitor his pressure closely. I discontinued his Lasix. John has no history of edema or lower extremity swelling. I am not quite sure why this was prescribed. I will call Dr. Carbain and inquire about the Lasix. I will let John know if Dr. Carbain disagrees with my discontinuing this based on his history. John understood this and the instructions / precautions. He seemed to be less anxious. Discussing his symptoms and his medications and the impact of his recent weight loss seemed to relieve him somewhat. He is also relieved that we will check on him in one week. He will see me again next Tuesday.

Charles Sims, M.D.
Electronically Signed September 1, 2011

3

Charles H. Sims, M.D.
Family Practice
7937 Hospital Blvd. East
Cunningham, Idaho 23556
547-793-7937

Exercise 4 Coding Answer Sheet

Patient: John Rogers

MR# 352369

DOB 3/17/1953

Date 9/15/2011

Name: Johns Rogers MD: Charles H. Sims

Service Date	CPT	Modifier	Dx 1	Dx2	Dx3	Dx4	POS	Injury Date
9/1/2011	99214		796.3	780.79	796.09	783.21	11	N/A
	CBC							
	A1C							
	Culture							

Diagnosis Codes:

796.3 Low blood Pressure
780.79 Generalized weakness
786.09 Dyspnea Respiratory –other
783.21 Abnormal Weight loss

Evaluation and management

History = Detailed = 99214
Exam = Comprehensive (1995) = 99215
MDM = Moderate = 99214
Overall level of E&M = 99214
CBC
A1C
Stool Culture
(Labs based on send outside or in house.)

Exercise 5	Clinical Documentation Report Review Sheet Surgical Report			
Patient Name First John			Last Rogers	
Date of Birth 3-17-53			Acct. #	997696500
Content	**YES**	**No**	**N/A**	**Comments**
Patient Identity on Each Page	X			
Facility Location Identified	X			
Hospital unique Identifiers	X			
Hospital Status				
In Patient				
Out-patient / Observation	X			
Date of Surgery	X			Sept. 7, 2011
Prophylactic Antibiotics		X		
Allergy Information		X		
Primary Surgeon Identified	X			
Assistant Surgeon Identified				
Anesthesia	X			Not complete under "anesthesia"
Preoperative Diagnosis	X			
Post-operative Diagnosis				
Procedure Title	X			
Informed Consent		X		
Indication for Procedure	X			
Results of Diagnostic Report		X		
Procedure Details	X			
Incidental Findings Positive or Negative	X			
Procedure Details	X			
Tissue or Organ Removed		X		Did not list # of specimes
Application / Insertion Implants			N/A	
Implant information			N/A	
Closure Type			N/A	
Drainage Application / Type			N/A	
Wound status			N/A	
Estimated Blood Loss			N/A	
Transfusion Information			N/A	
Complications Described		X		
Patient's Tolerance of Procedure		X		
Signatures	X			
Legibility	X			
CC Notes as Applicable	X			
Date of Dictation and Transcription	X			TRANSCRIPTION DATE id MISSING
Reviewer's Name:			Date of Review:	

High City Hospital
207688 Hospital Drive
Cunningham Idaho, 23556

Medical Record # 00997696500
Status Out Patient Same Day Unit

Patient Name: John Rogers

DOB: 3-17-1953

Date of service: September 7, 2011

Provider: Richard Jones, M.D.

Assistant Surgeon:

Anesthesia: 6 mg of Versed and 100 mcg of Fentanyl

Preoperative Diagnosis: Unexplained anemia, previous history of polyps**,** Positive fecal blood

Postoperative Diagnosis: Neoplasm rectum unspecified
Definitive diagnosis pending pathology report

Procedure Performed: Diagnostic colonoscopy

Indications for procedure: The patient presented to the office of his PCP Dr, Charles Sims, complying of low blood pressure. He was very concerned as he has a history of an ICD implant and is under the care of his cardiologist for this. His cardiologist was unable to see him as soon as he wanted to be seen. Therefore he called Dr. Sims. The patient has recently lost 15 lbs., and Dr. Sims adjusted his medication due to the recent weight loss and after running blood work diagnosed him as being anemic. This was concerning to the Dr. Sims as three years ago Mr. Rogers underwent a routine colonoscopy for preventive health and several polyps were removed from his colon. Mr. Jones is only three years out of his last screening colonoscopy. He is not due for another routine screening until 2015. Due to his current anemia, and positive for fecal occult blood, he felt this patient should undergo another diagnostic colonoscopy. Mr. Rogers does report that his uncle and grandfather passed due to colon cancer. After discussion concerning the procedure and informed consent the patient was taken to the diagnostic suite.

PROCEDURE

With the patient in the left lateral position and after sedation using 6 mg of Versed and 100 mcg of Fentanyl, the Olympus adult colonoscope was inserted and advanced to the cecum. The ileocecal valve and appendiceal openings were normal. The scope was withdrawn with the viewing circumferentially the cecum, right colon, hepatic flexure, transverse colon, splenic

High City Hospital
207688 Hospital Drive
Cunningham Idaho, 23556

Medical Record # 00997696500
Status Out Patient Same Day Unit

flexure, left colon, and sigmoid. Diverticular opening noted. In the distal rectum there were multiple irregular lesions I performed a biopsy on each of these lesions. These were sent to pathology for identification.

Patient Name: John Rogers

DOB: 3-17-1953

Date of service: September 7, 2011

Provider: Richard Jones, M.D.

The scope was taken from the field the patient was awakened and taken to the taken to recovery in stable condition. There we no complications during the procedure.

I will see Mr. Rogers in the office in three days to discuss his path report.

Richard Jones, M.D.

Electronically signed, 9-18-11

Transcribed September 17, 2011 ID#578899

CC: Charles Sims, M.D.

NOTE:

Pathology report Dated September 9th revealed rectal adenocarcinoma (metastatic)

Patient underwent PET scan revealing primary neoplasm lung, right upper lobe.

CPT 45380

IDC-9-CM

197.5 M-N rectum secondary

162.3 Primary neoplasm lung upper lobe

High City Hospital
207688 Hospital Drive
Cunningham Idaho, 23556

Medical Record # 00997696500
Status Out Patient Same Day Unit

Exercise # 5 Coding Sheet

Patient: John Rogers

MR#

DOB: 03/17/1953

Date: September 7, 2011

MD: Richard Jones, M.D.

Service Date	CPT	Modifier	Dx 1	Dx2	Dx3	Dx4	POS	Injury Date
09-07-11	45380		197.5	162.3			22	N/A

NOTE:

Pathology report Dated September 9th revealed rectal adenocarcinoma (metastatic)

Patient underwent PET scan revealing primary neoplasm lung, right upper lobe.

CPT 45380

IDC-9-CM

197.5 M-N rectum secondary

162.3 Primary neoplasm lung upper lobe

Subject:	Colonoscopy		
Guideline #:	CG-SURG-01	**Current Effective Date:**	07/13/2011
Status:	Reviewed	**Last Review Date:**	05/19/2011

Anthem Blue Cross Blue Shield

Diagnostic Colonoscopy

Medically Necessary:

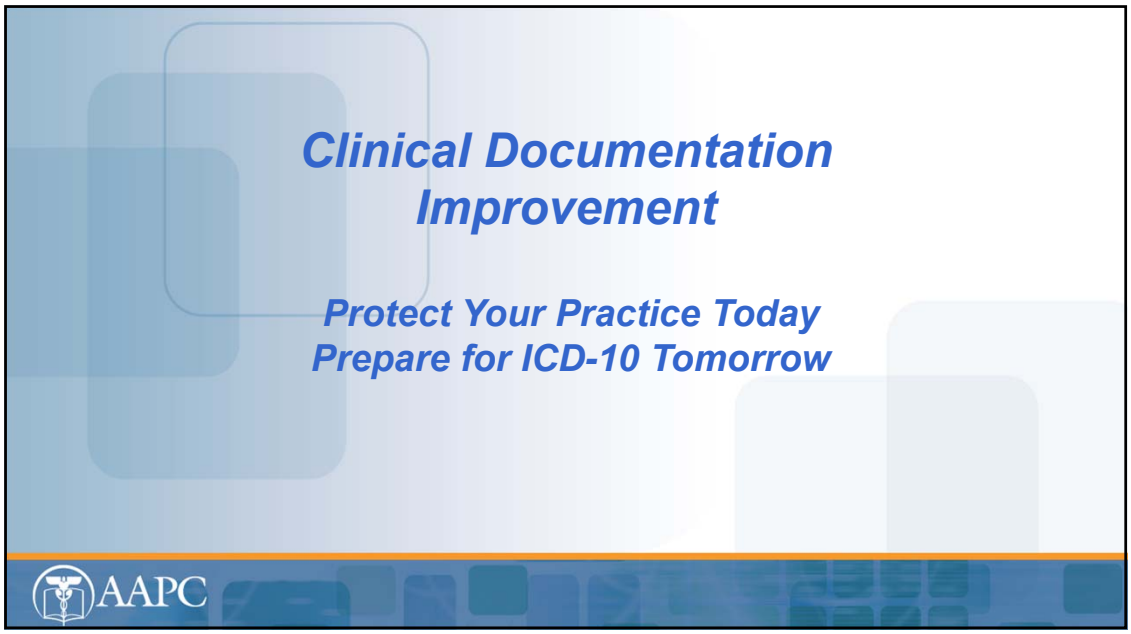
Diagnostic Colonoscopy is indicated for the evaluation of any of the following:

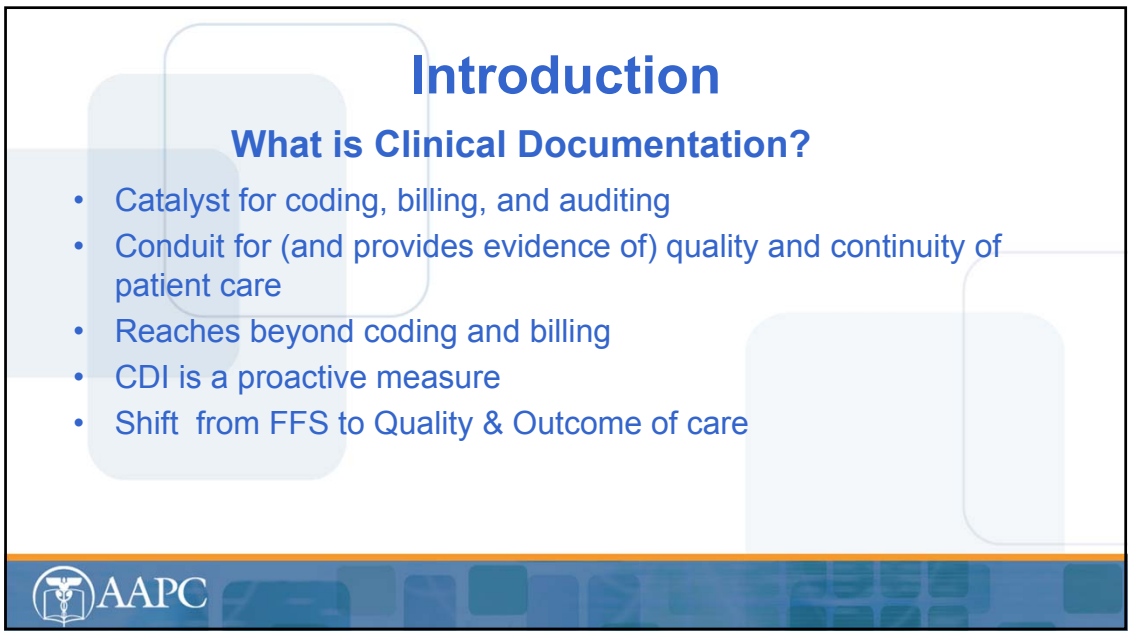
- an abnormality on barium enema or other imaging study that is likely to be clinically significant (filling defect, stricture); (3) or
- unexplained gastrointestinal tract bleeding such as: (3)
  - hematochezia (3) or
  - melena after an UGI tract source has been excluded; (3) or
  - presence of fecal occult blood (3) or
  - unexplained iron deficiency anemia; (3) or
- a suspicion of inflammatory bowel disease, which may be manifested by abdominal pain, fever, diarrhea, bloody diarrhea, elevated erythrocyte sedimentation rate, etc.; or
- clinically significant diarrhea of unexplained origin (3) after other appropriate work up; or
- a metastatic adenocarcinoma of unknown primary origin when colon cancer is suspected; (10) or
- Intraoperative identification of a lesion not apparent at surgery (e.g., polypectomy site, location of a bleeding site). (3)

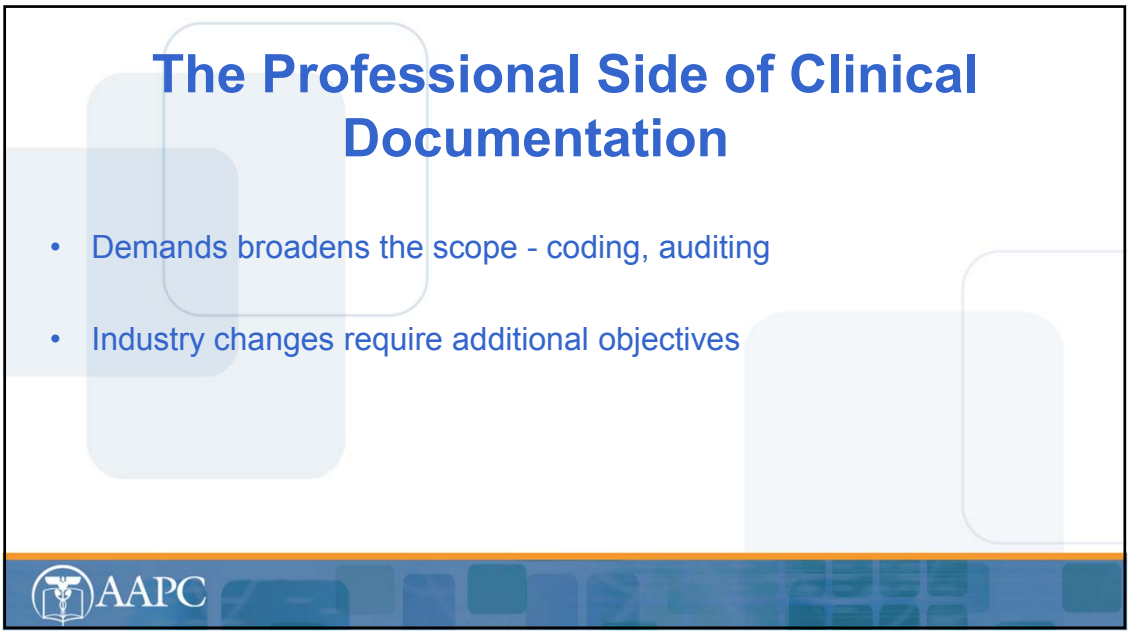
Not Medically Necessary:

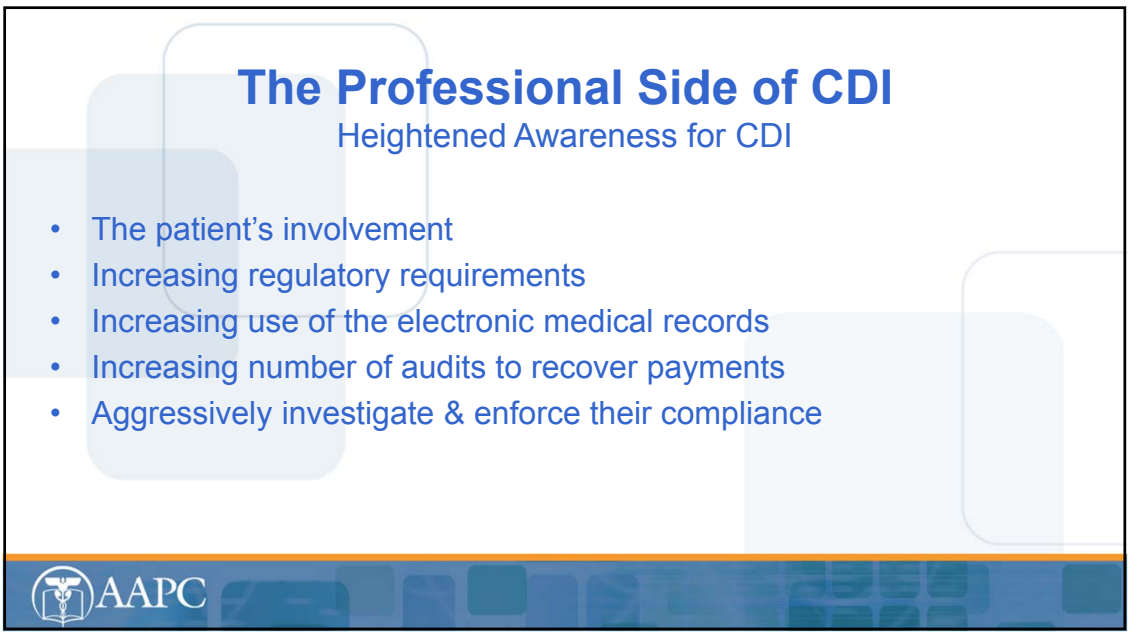
Other indications for diagnostic colonoscopy, not listed above are considered **not medically necessary,** including but not limited to the following:

- chronic, stable irritable bowel syndrome; (3, 9) and
- chronic abdominal pain; (3, 9) and
- acute diarrhea; (3, 9) and
- routine follow-up of inflammatory bowel disease except for cancer surveillance in chronic ulcerative colitis and Crohn's colitis; (3, 9) and
- Upper GI tract bleeding or melena with a demonstrated upper GI source. (3, 9)


Clinical Documentation Improvement
Protect Your Practice Today
Prepare for ICD-10 Tomorrow
AAPC


Introduction
What is Clinical Documentation?
Catalyst for coding, billing, and auditing
Conduit for (and provides evidence of) quality and continuity of patient care
Reaches beyond coding and billing
CDI is a proactive measure
Shift from FFS to Quality & Outcome of care
AAPC





The Professional Side of CDI

Heightened Awareness for CDI

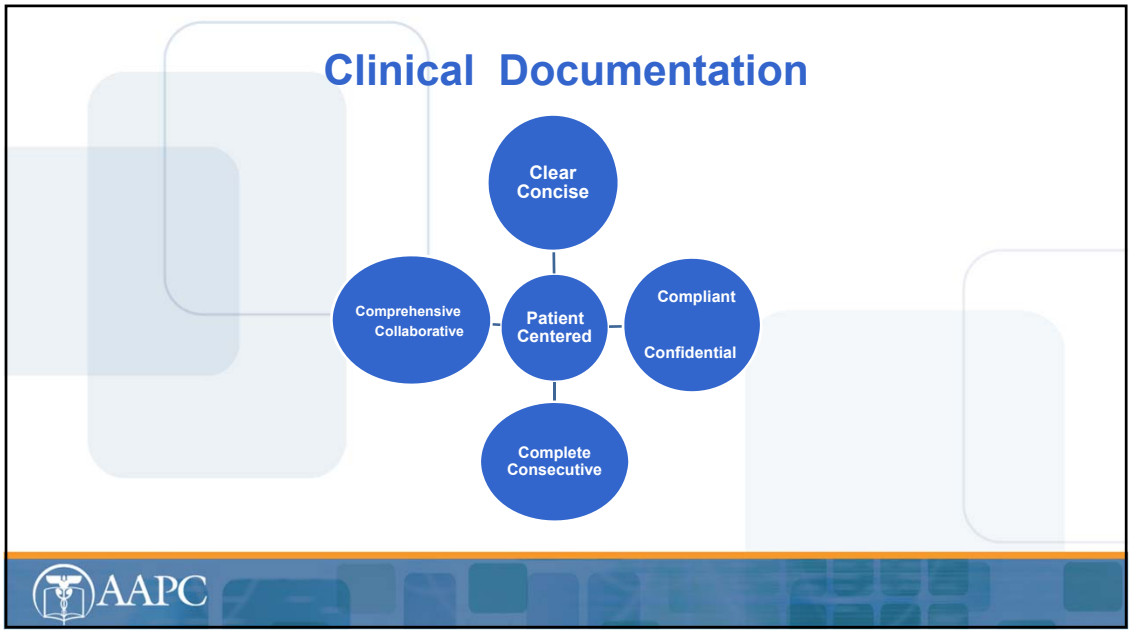
- "Business Side of Medicine" continuously evolving
- Requires highly skilled auditors, coding, & CDS
- Individual or team facilitate effective change with CDI

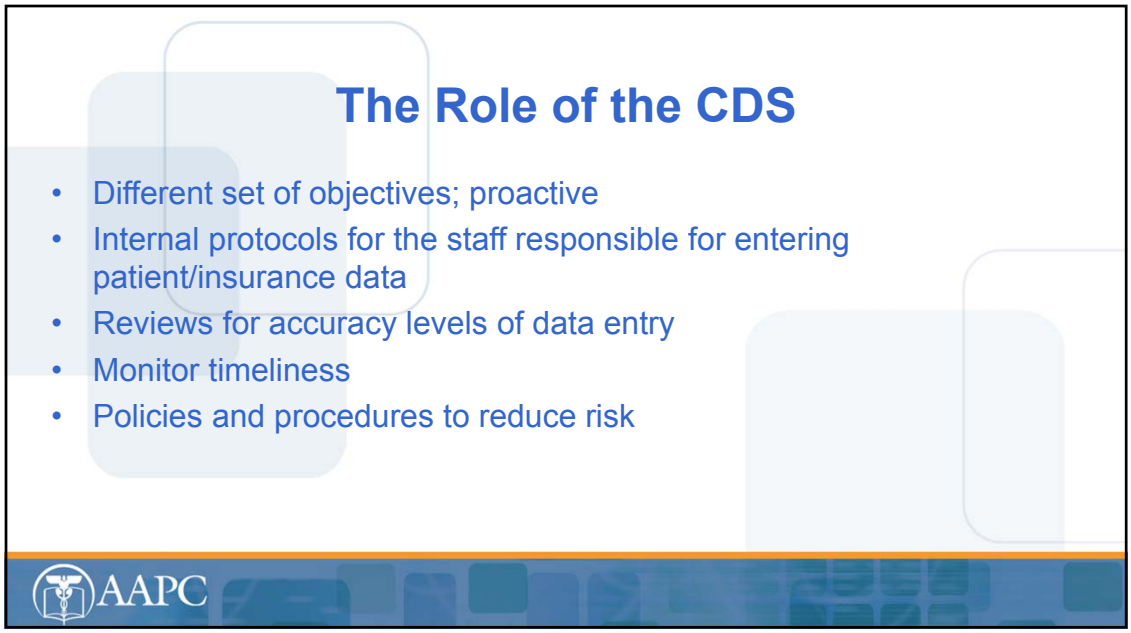
AAPC

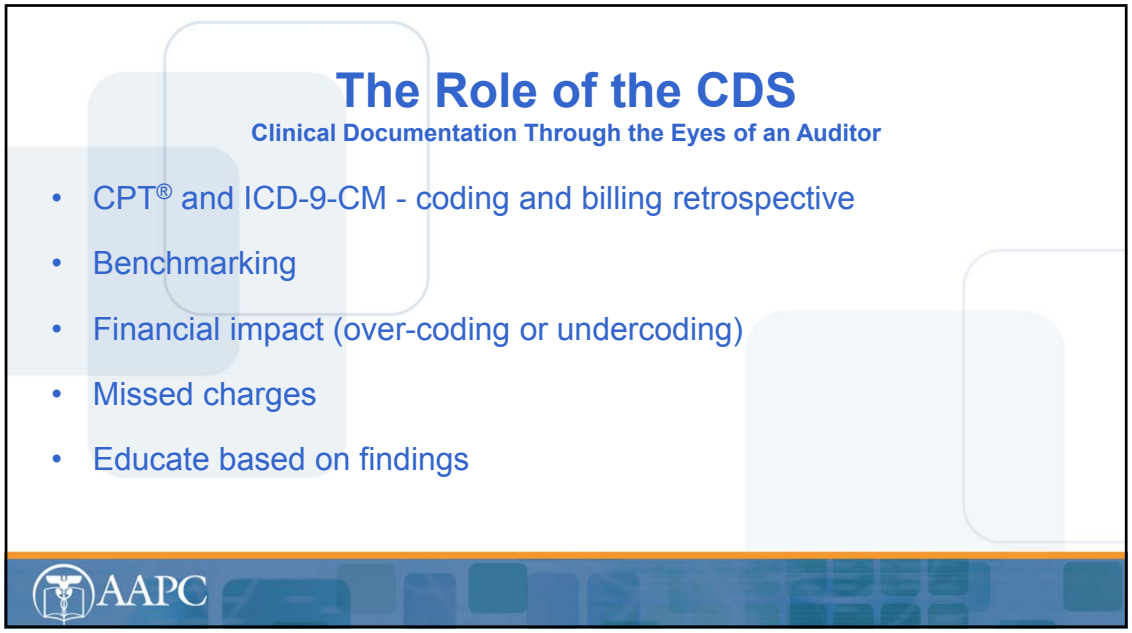
Agenda

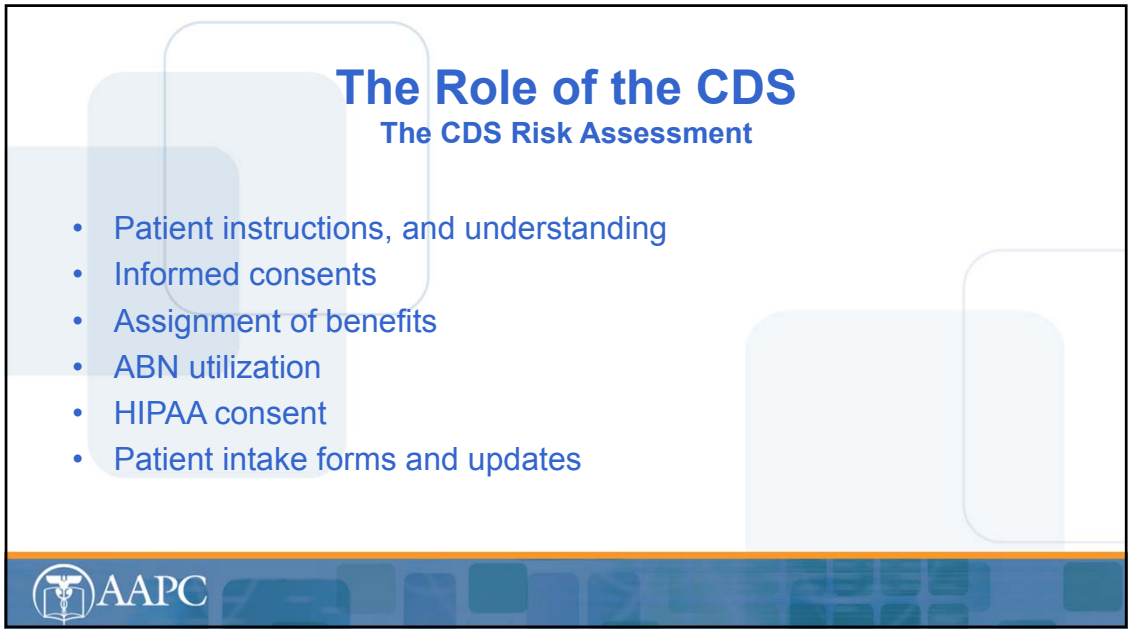
- The role of the CDS
- The Quality of Documentation
- The Electronic Medical Record (EMR)
- Mastering the Documentation Process
- The Impact of ICD-10 on Clinical Documentation
- Coding and Abstracting
- Implementation of a CDI program
- Hands-on Activities

AAPC






The Role of the CDS
Clinical Documentation Through the Eyes of an Auditor
• CPT® and ICD-9-CM - coding and billing retrospective
• Benchmarking
• Financial impact (over-coding or undercoding)
• Missed charges
• Educate based on findings
AAPC


The Role of the CDS
The CDS Risk Assessment
• Patient instructions, and understanding
• Informed consents
• Assignment of benefits
• ABN utilization
• HIPAA consent
• Patient intake forms and updates
AAPC

The Role of the CDS

Risk Assessment

- Patient signatures and completion of forms.
- Medication lists updates
- Allergies updates
- Quality of care indicators
- The use of acronyms
- Correcting a deficient record
- Cloning

AAPC

The Role of the CDS

Comprehensiveness

Does this record…

- Stand alone?
- Show evidence of the nature and severity of the problem?
- Show evidence of the services rendered & charged
- Show provider's assessment and plan complete enough for another clinician or take over the case?
- Show enough comprehensive information to protect the provider in court?

AAPC

The Role of the CDS

Communicate Educate Facilitate

- The CDS must also be able to train providers and staff
  - Detail
  - Quality
  - Accuracy
- Medical record serves a multitude of purposes. The CDS plays a vital role in ensuring documentation appropriate for ALL aspects of the health care industry needs.

AAPC

Fundamentals

"If it isn't documented, it hasn't been done."

"The failure of a physician practice to: (i) document items and services rendered; and (ii) properly submit the corresponding claims for reimbursement is a major area of potential erroneous or fraudulent conduct involving Federal health care programs. The OIG has undertaken numerous audits, investigations, inspections and national enforcement initiatives in these areas."

Federal Register */ Vol. 65, No. 194 / Thursday, October 5, 2000*
Page 59439

AAPC

Fundamentals

- Coding and reporting may be accurate technically;
  Medical necessity requirements,
  Limitations of coverage, and
  Documentation requirements not met
- Claims may meet the “technical” coding requirements;
  Fails to meet the medical necessity, inaccurate information

AAPC

Chapter 2
The Quality of Documentation

- Without quality and evidence of care
  - Vulnerability
  - Risk

AAPC

Chapter 2
The Quality of Documentation

- Requests for medical documentation from contractors paid by CMS for (HCC) and HEDIS.
- The only evidence the providers have.

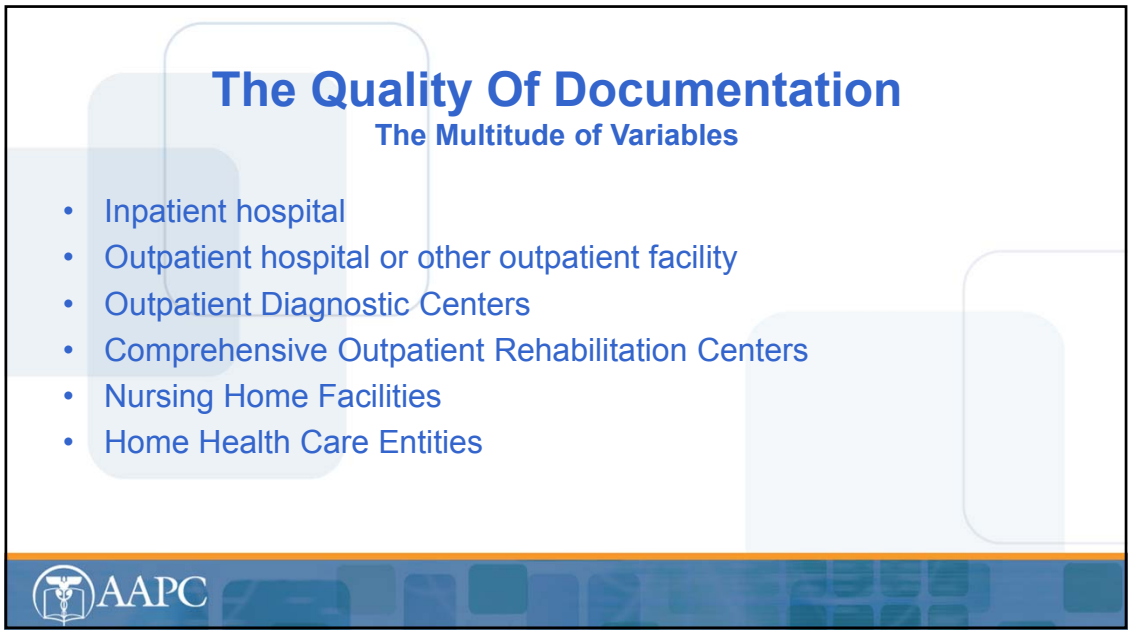
AAPC

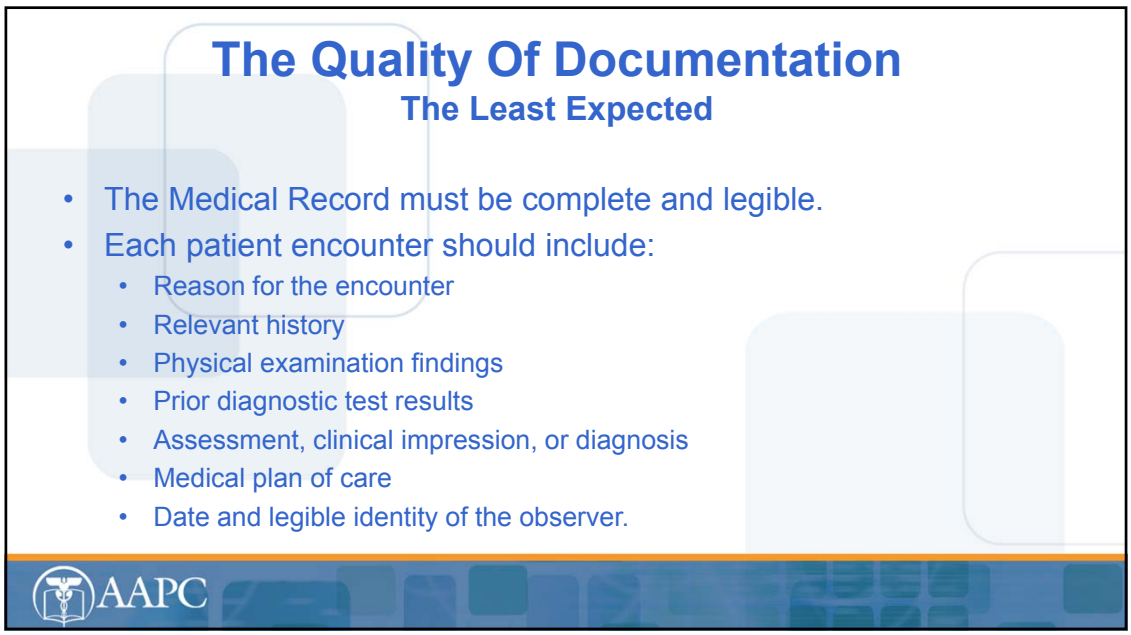
The Quality of Documentation

The Multitude of Requests
Records are being Scrutinized

- CMS Contractors, HCC, HEDIS
- Patients
- Attorneys
- Other Providers
- Workers' compensation
- Payers for precertification
- Pre-employment applications
- Military application
- SSI applications

AAPC





The Quality Of Documentation
The Least Expected

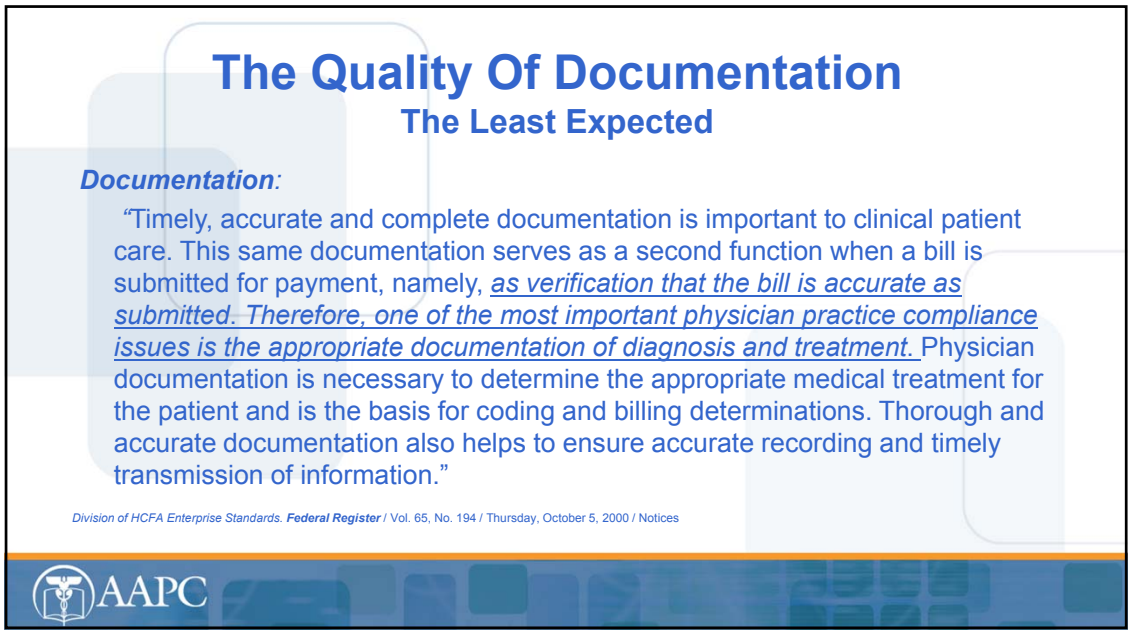
- When ordering diagnostic or other ancillary services, the rationale for ordering should be easily inferred if it is not specifically documented.
  - The past and present diagnoses should be accessible to the treating and/or consulting physician.
  - All appropriate health risk factors should be clearly identified in the record and the patient's progress and response to treatment, or changes in treatment should be clear.

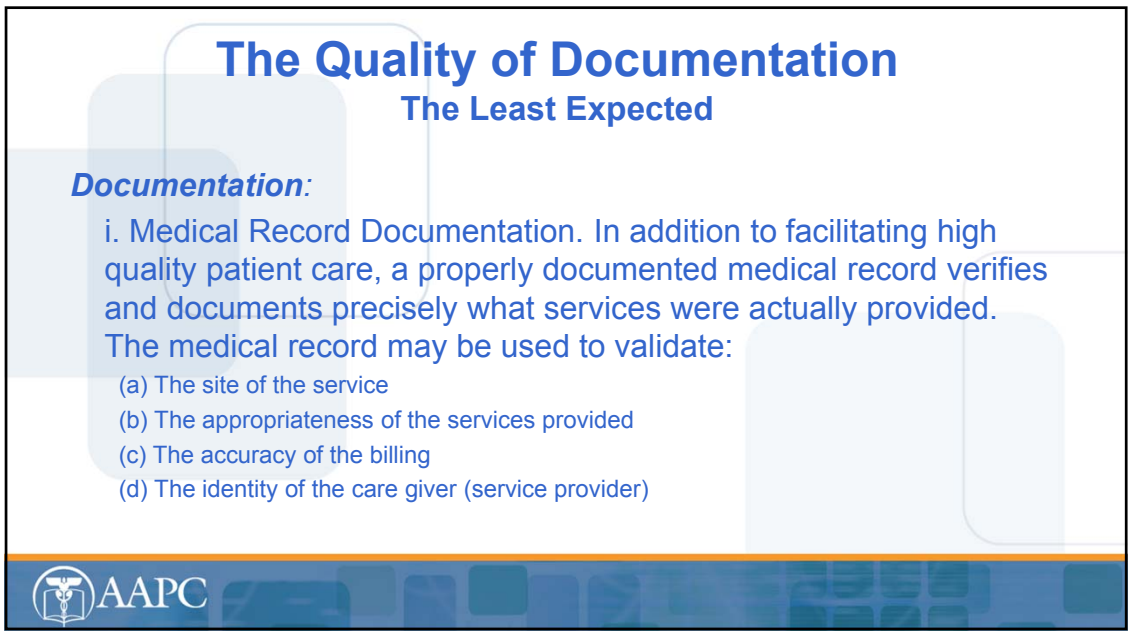
AAPC

The Quality Of Documentation
The Least Expected

- Every record should support the charges submitted on the claim or patient statement.
- The medical record should be:
  - Complete
  - Precise
  - Reliable
  - Consistent
  - Legible (as stated above)
  - Timely

AAPC



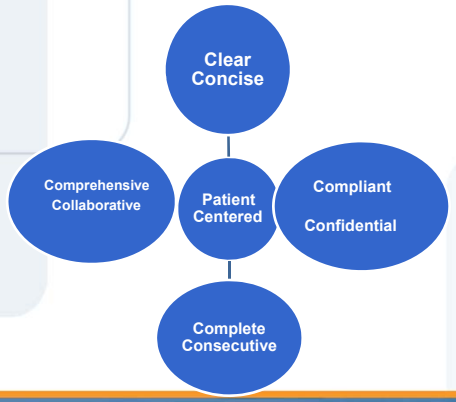


The Quality of Documentation "Patient Centered"

"The OIG acknowledges that patient care is, and should be, the first priority of a physician practice. However, a practice's focus on patient care can be enhanced by the adoption of a voluntary compliance program. For example, the increased accuracy of documentation that may result from a compliance program will actually assist in enhancing patient care."

AAPC

The Quality of Documentation "Patient Centered"



AAPC

The Quality of Documentation "Patient Centered"

- Improve the communication and the dissemination of information between and across all providers of services.
- Provide the appropriate amount of treatment, intervention, and plan of care.
- Improve goal setting and evaluation of care outcomes.
- Improve early detection of problems and changes in health status.
- Provide "EVIDENCE" of excellent patient care.

AAPC

The Quality of Documentation Timing

- To maintain an accurate medical record, services should be documented during the encounter or as soon as practical after the encounter.
  - Speech recognition dictation intergraded into the EMR
  - Pre-populated templates, specialty specific
  - Hard copy forms the patient completes describing their condition, problems, injury
  - Macros
  - Utilization of standard acronyms
  - Support staff contributing to the record

AAPC

The Quality of Documentation

Abbreviations / Communications

For example,

If a provider writes "HTN" when a patient has benign hypertension, there should be a protocol written for the office personnel stating when "HTN" is written in the patient's chart or on a fee ticket, it is to be coded as benign hypertension unless otherwise specified. If no protocol exists and "HTN" is documented, the appropriate way to code "HTN" would be hypertension unspecified.

AAPC

The Quality of Documentation

Abbreviations / Communications

For example:

The abbreviation "I&D". Is the provider meaning irrigation and debridement or irrigation and drainage? Again, this is an example where protocols and provider/staff communication can eliminate many problems and improve efficiency.

- "U" or "u" should not be used for unit. The provider must document, for example, "5 units." This can be a common problem in the hospital setting. Joint Commission now requires the term "unit" be specified. This type of compliance measure should carry over in the office setting.

AAPC

The Quality of Documentation
Abbreviations / Communications

This example is not an abbreviation but is common communication issue.

"urosepsis."
What does the provider mean?

The protocol should state that unless otherwise documented, the term "urosepsis" is infection in the urinary system only.
Each time a coder sees this diagnosis he or she will report urosepsis.
There will be no need to query the provider if the bacteria has progressed to septicemia or sepsis.

AAPC

The Quality of Documentation
Diagnostic Data

- The patient diagnosis
  - "It is What it Is"
- The code selection may be different
- Outpatient versus inpatient

AAPC

The Quality of Documentation
Financial Impact

The inaccuracy of medical documentation

- Loss in revenue
- Selecting codes of lesser value
- Overpayment and underpayment
- Payment recoupment – denials - fines - penalties

AAPC

The Quality of Documentation
Financial Impact

Procedures designated in CPT®

- 10060 Simple
- 10061 Complicated

AAPC

The Quality of Documentation

Legal Protection

- If the record is evidence in court, would it be comprehensive enough to support and protect the provider?
- Would this record support the patient in a claim against another party?
- If involved with a RAC audit would an appeal stand based on the record?

AAPC

Chapter 3

The Electronic Medical Record

Advantages

- Ease of information sharing
- Immediate access to patient information
- Acceleration of claim transmission
- Decrease in transcription
- Template enhances speed and details
- Legible
- Timely

AAPC

The Electronic Medical Record Pitfalls

- Copy and paste or "cloning" OIG Work Plan for 2012.
- Repetition. Some payers state records without "unique" patient information will be denied for medical necessity.
- Information should be pertinent to the current encounter
  - A comprehensive history on the same patient that was seen two or three weeks prior may not be required.

AAPC

The Electronic Medical Record Pitfalls

- "Fluff"
  - Templates that contain pages of useless information
  - Staff copying forward information not knowing what is needed
  - More is not always better

AAPC

The Electronic Medical Record

OIG Work Plan 2012

Potentially Inappropriate Payments

We will assess the extent to which CMS made potentially inappropriate payments for E/M services and the consistency of E/M medical review determinations. We will also review multiple E/M services for the same providers and beneficiaries to identify electronic health records (EHR) documentation practices associated with potentially improper payments. ***Medicare contractors have noted an increased frequency of medical records with identical documentation across services***. Medicare requires providers to select the code for the service based upon the content of the service and have documentation to support the level of service reported.

AAPC

The Electronic Medical Record

Authentication of Author

- More than one care giver must be able to enter and delete
- EMR should have the capability to save and display the author and date of each entry
- Capability for two signatures

AAPC

The Electronic Medical Record
Integrity of Patient Data

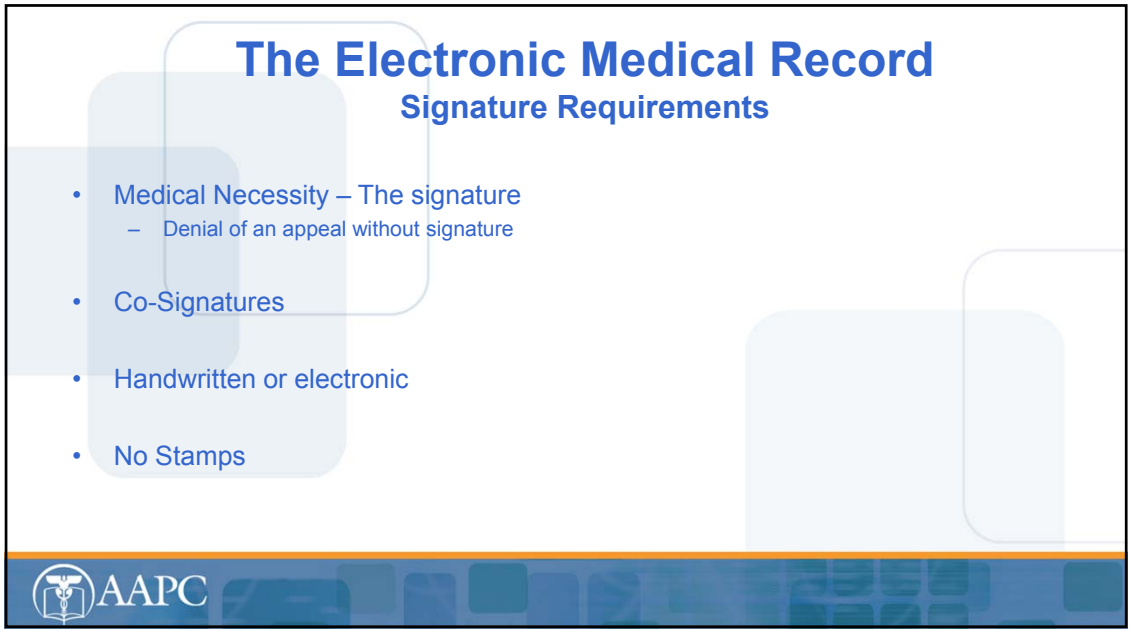
- Track data entries to maintain accountability
- Maintain password integrity
- Defaults
  - Accounts should be updated at each encounter
- Generating claims with incorrect patient data is abusive
- CDS monitors reports for incorrect data

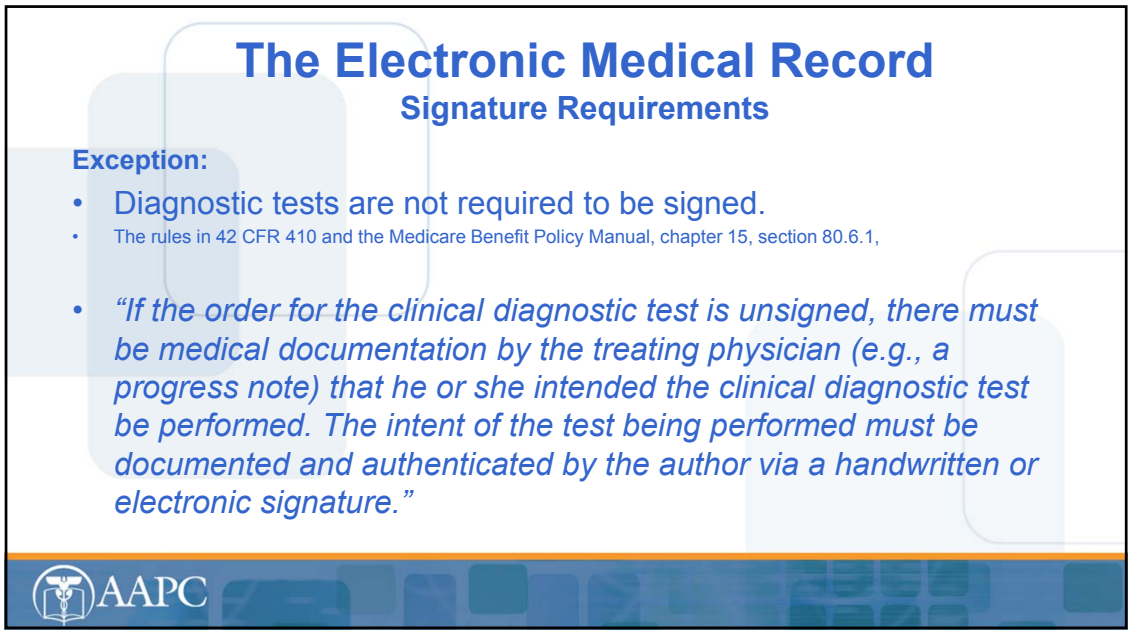
AAPC

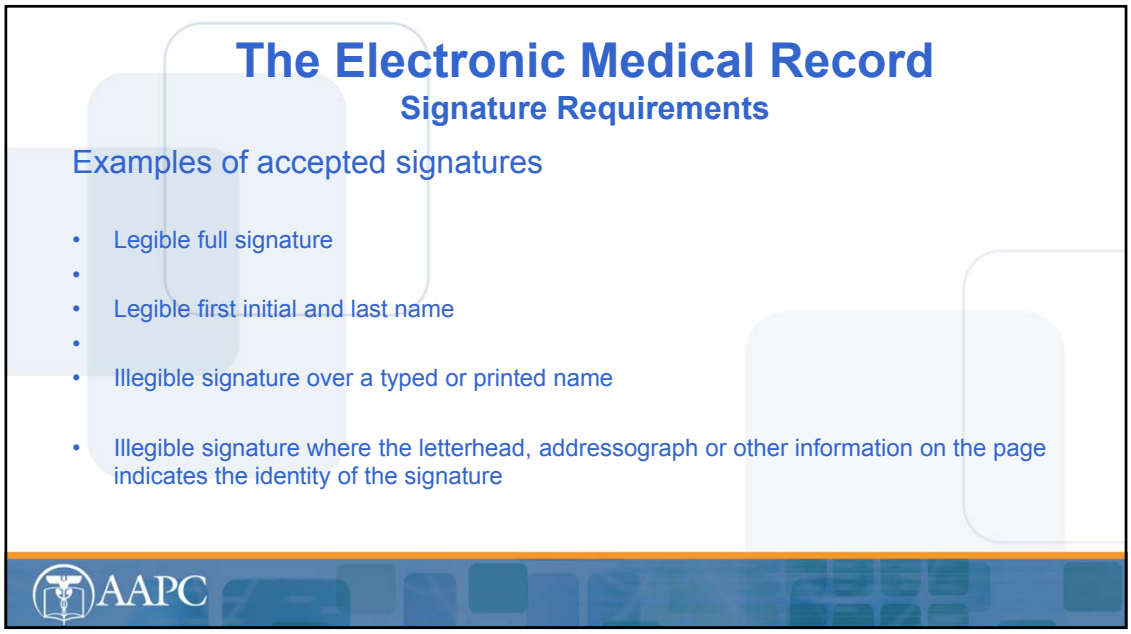
The Electronic Medical Record
Computer Assisted Coding

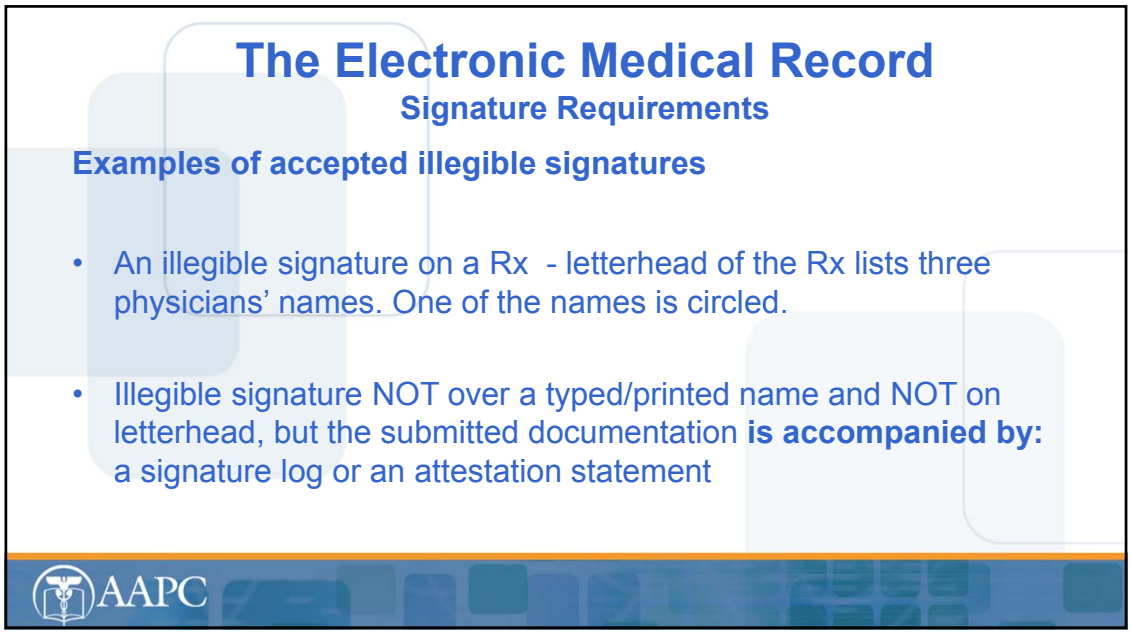
- Computer counts populated elements in the EMR assigns codes.
- If documentation is not sufficient, CAC assigns a lower level code. If medical necessity meets higher level? Records coded low?
- Can code based on 1995 or 1997 documentation guidelines.
- Does not have the capability to assign a code based on subjectivity.
- The CDS should monitor CAC claims and provider records to make sure CAC is the best tool for the provider.

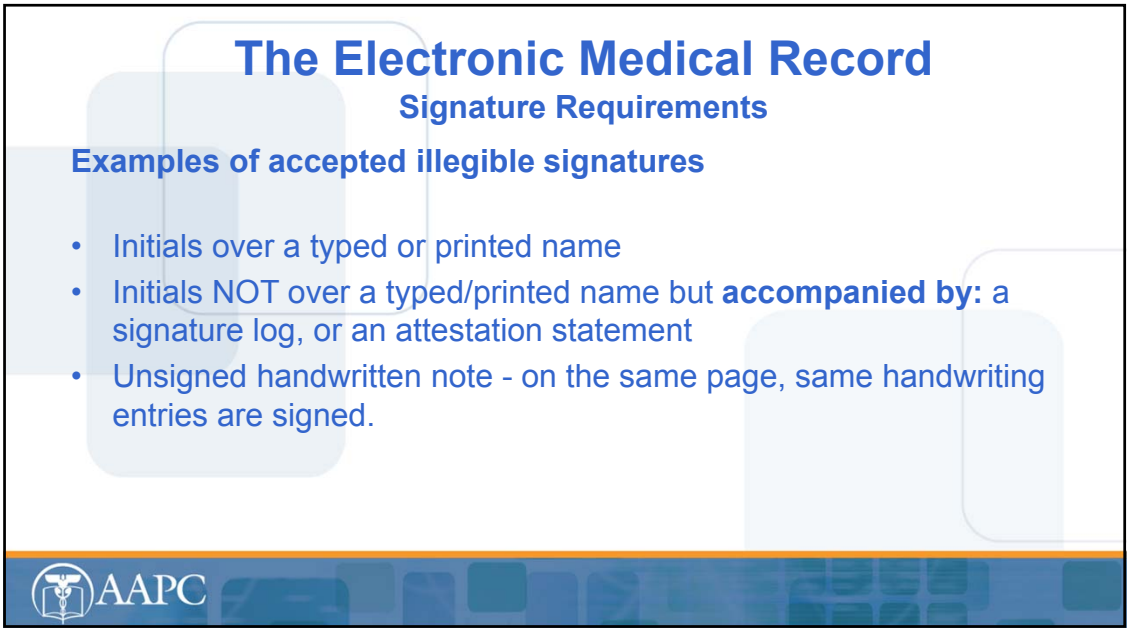
AAPC

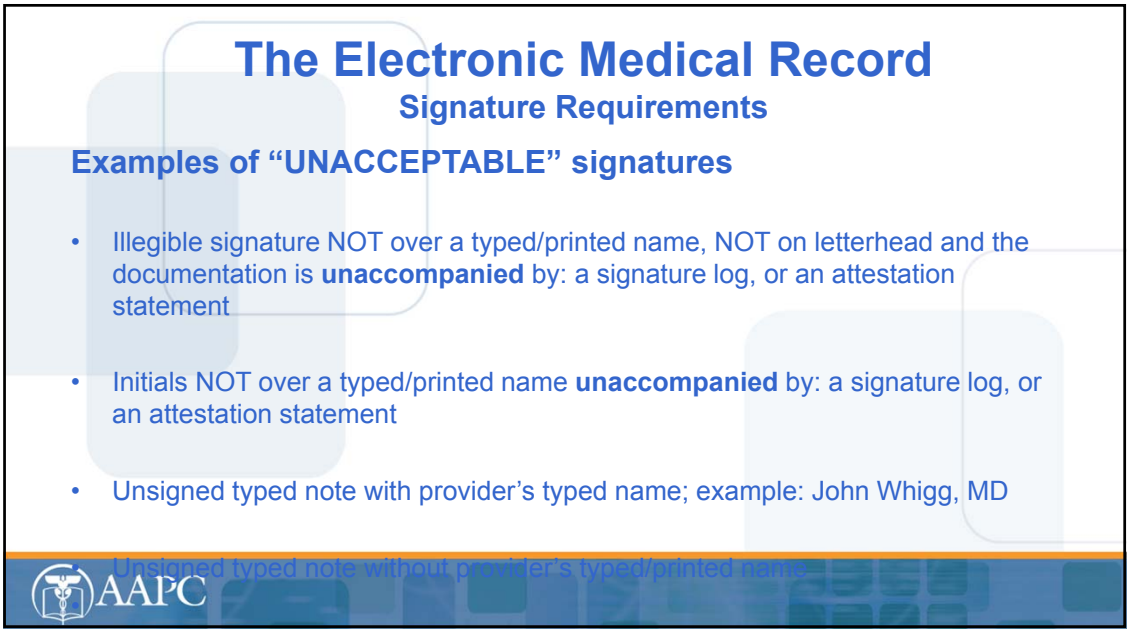





The Electronic Medical Record
Signature Requirements
Examples of accepted signatures
Legible full signature
Legible first initial and last name
Illegible signature over a typed or printed name
Illegible signature where the letterhead, addressograph or other information on the page indicates the identity of the signature
AAPC


The Electronic Medical Record
Signature Requirements
Examples of accepted illegible signatures
An illegible signature on a Rx - letterhead of the Rx lists three physicians' names. One of the names is circled.
Illegible signature NOT over a typed/printed name and NOT on letterhead, but the submitted documentation is accompanied by: a signature log or an attestation statement
AAPC





The Electronic Medical Record
Signature Requirements

Examples of "UNACCEPTABLE" signatures

- Unsigned handwritten note, the only entry on the page
- "Signature on file"

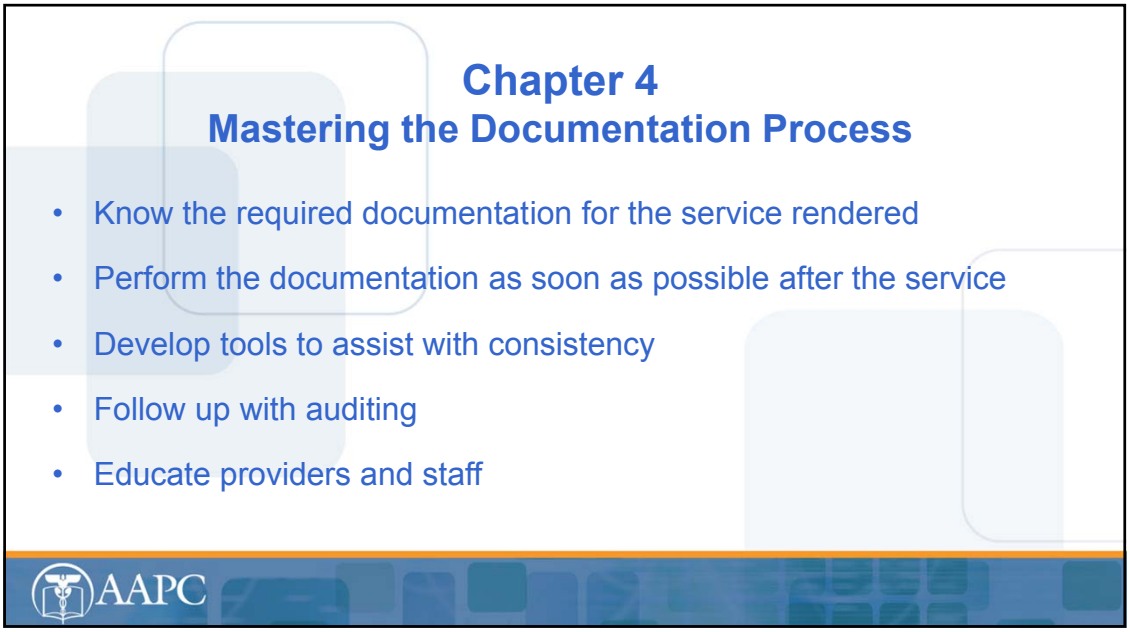
Providers should not add late signatures to the record

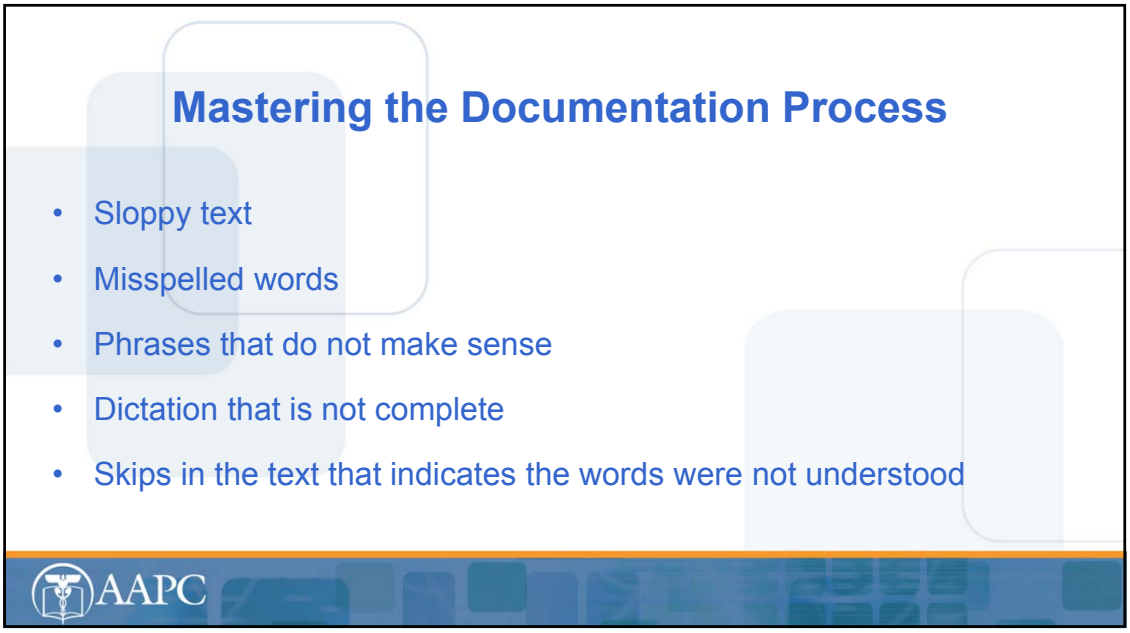
AAPC

The Electronic Medical Record
Patient Confidentiality

- No unauthorized access
  - Treatment
  - Processing
  - Payment
- Lock systems
- HIPAA training

AAPC





Mastering the Documentation Process

- Incomplete sentences
- Evidence of cloning or copying data from previous dates of service that is not relevant to the current service
- Incorrect dates of service
- Missing dates of service
- Missing dosage and strength of medication ordered

AAPC

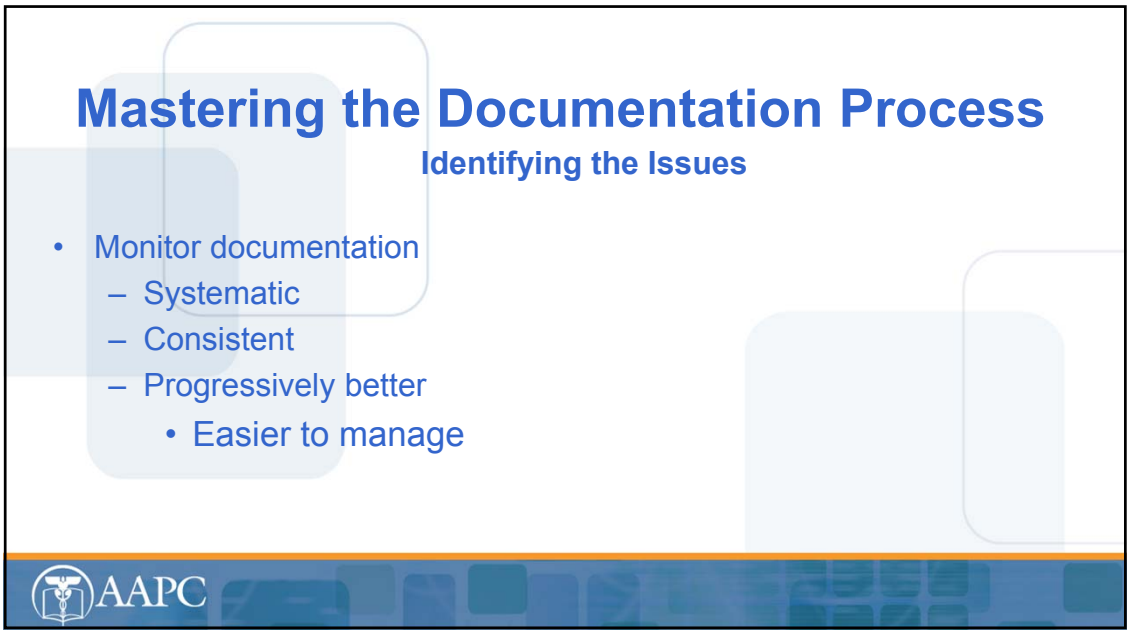
Mastering the Documentation Process

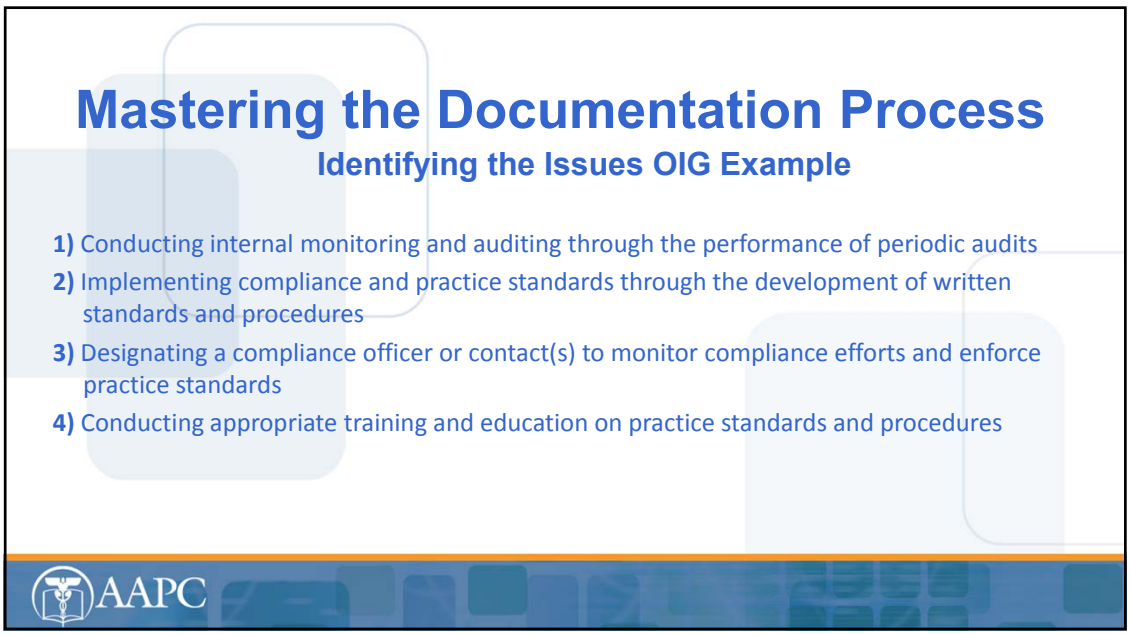
Accuracy

- Clean claims
  - Reduce appeals
  - Reduce claims going to "Never-Never Land"
  - Communication!

Best internal communication to all staff concerning the patient

AAPC





Mastering the Documentation Process

Identifying the Issues OIG Example

5) Responding appropriately to detected violations through the investigation of allegations and the disclosure of incidents to appropriate Government entities

6) Developing open lines of communication, such as (1) discussions at staff meetings regarding how to avoid erroneous or fraudulent conduct and (2) community bulletin boards, to keep practice employees updated regarding compliance activities; and

7) Enforcing disciplinary standards through well-publicized guidelines

These seven components provide a solid basis upon which a physician practice can create a compliance program

AAPC

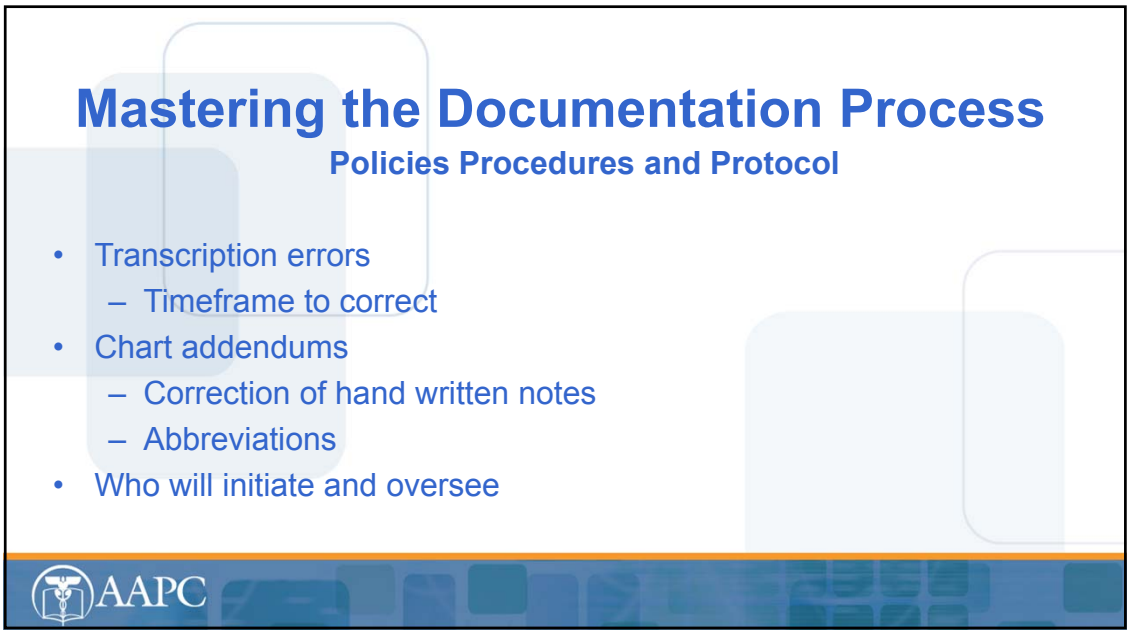
Mastering the Documentation Process

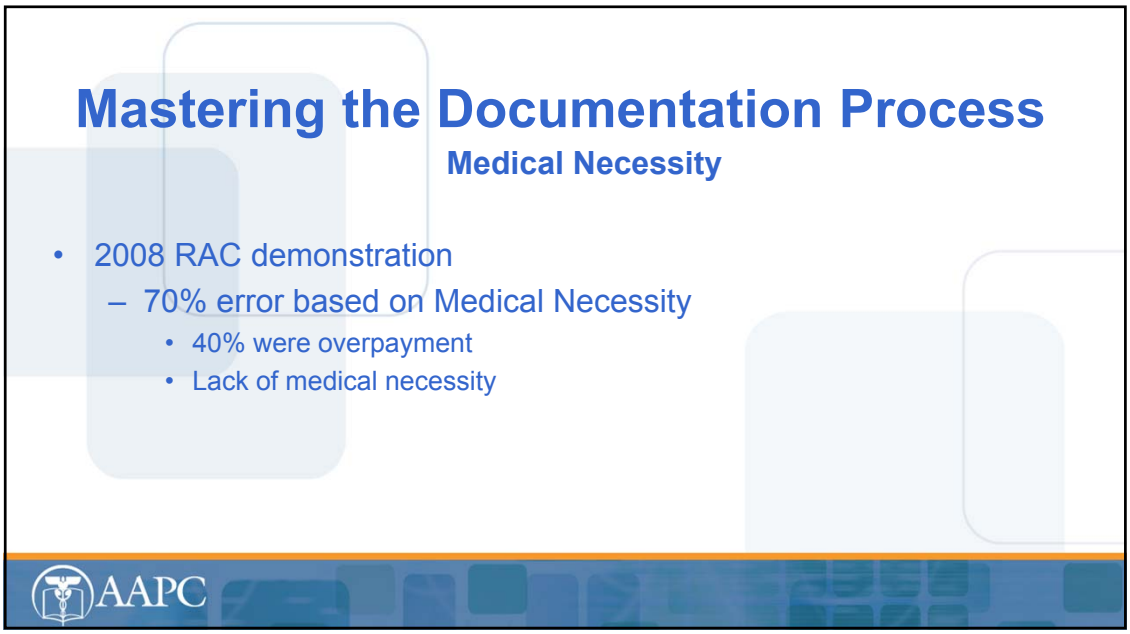
Policies Procedures and Protocol

- Physician queries
  - EMR
  - Manual
  - Base line # before required education
  - Storage
- Pending claims

Who will initiate and oversee?

AAPC





Mastering the Documentation Process

Medical Necessity

- Medical necessity drives:
  - Code selection
  - Services performed
  - Procedures and services ordered

AAPC

Mastering the Documentation Process

Medical Necessity

- Fraud $8.5 million dollar settlement New York
  - contraindicated and un-performed ophthalmologic services
    - *permanently excluded from all federally- funded health plans*
- Medical charts did not justify the wide scope of services for which he submitted bills
- Created and submitted new documentation - sometimes years after the questioned dates of service - to attempt to justify his claims after Medicare requested supporting documentation

AAPC

Mastering the Documentation Process

Medical Necessity

- Fraud $1.3 million dollar settlement, California
  - Qui tam
  - Performed on patients who responded to advertisements by a hospital neurologist.
  - Every patient same diagnosis, radiculopathy
  - Perform the tests himself, after normal business hours, without other physicians present. The neurologist billed Medicare for more tests than could normally be done in the amount of time.

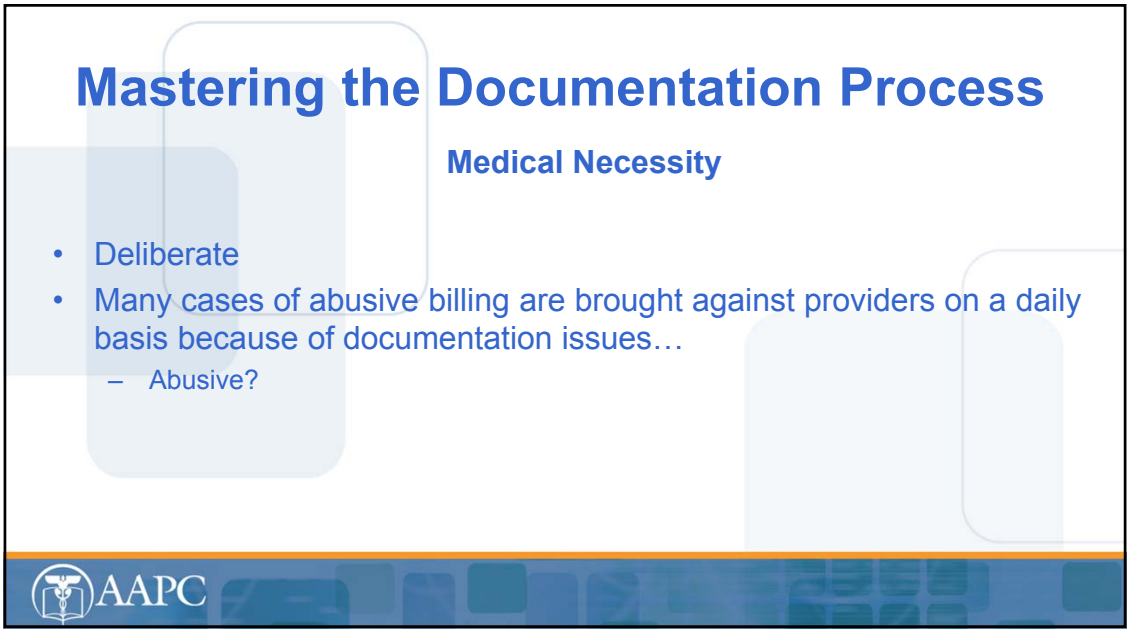
AAPC

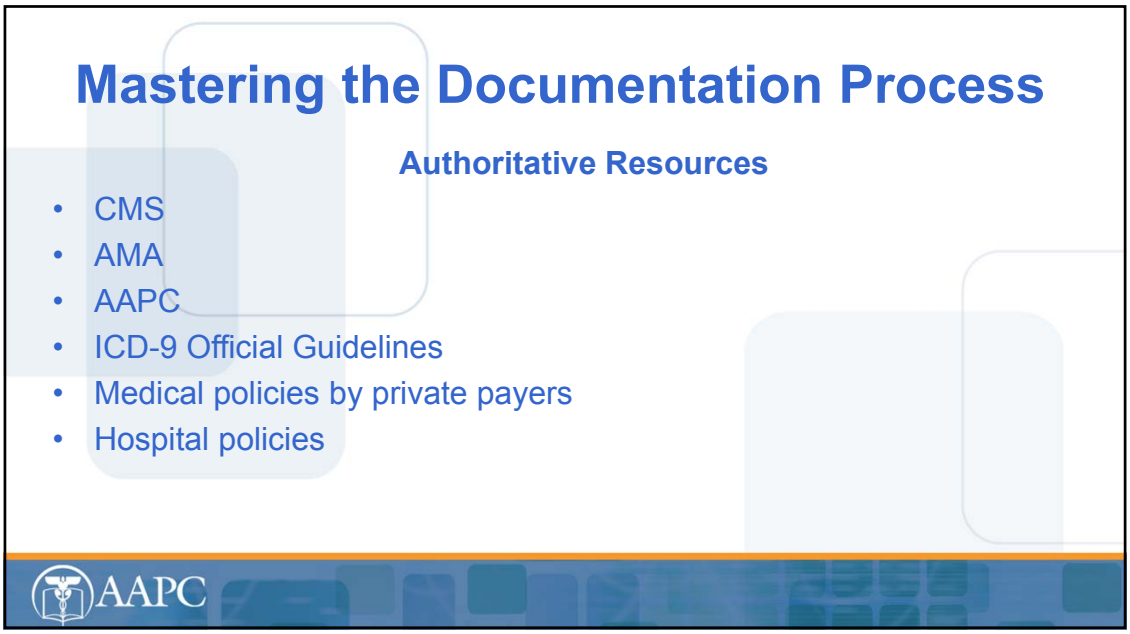
Mastering the Documentation Process

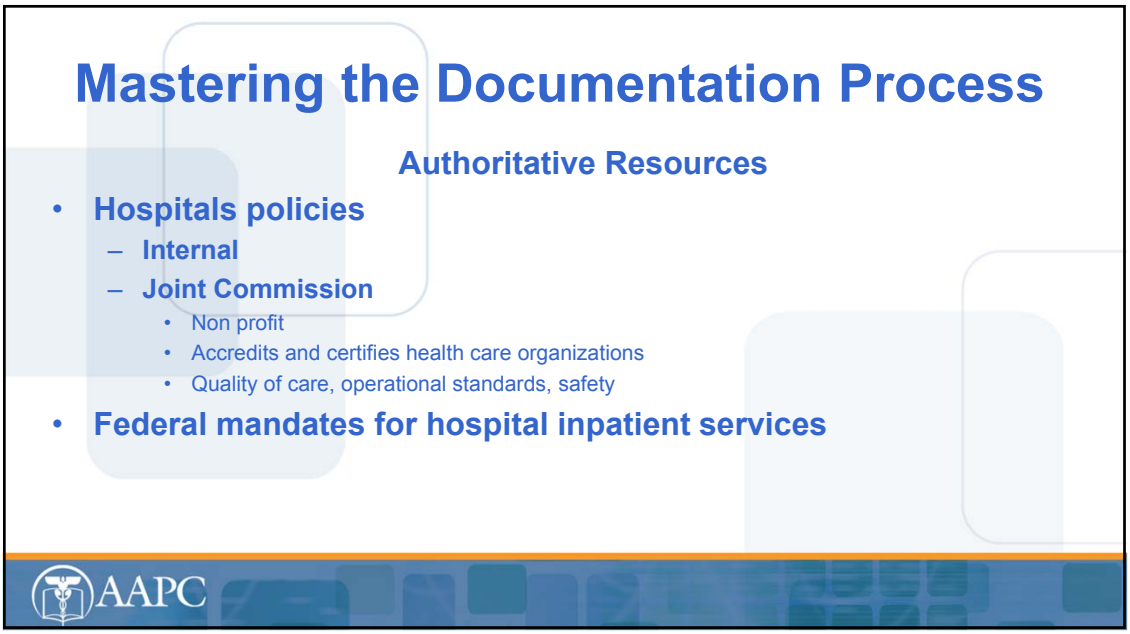
Medical Necessity

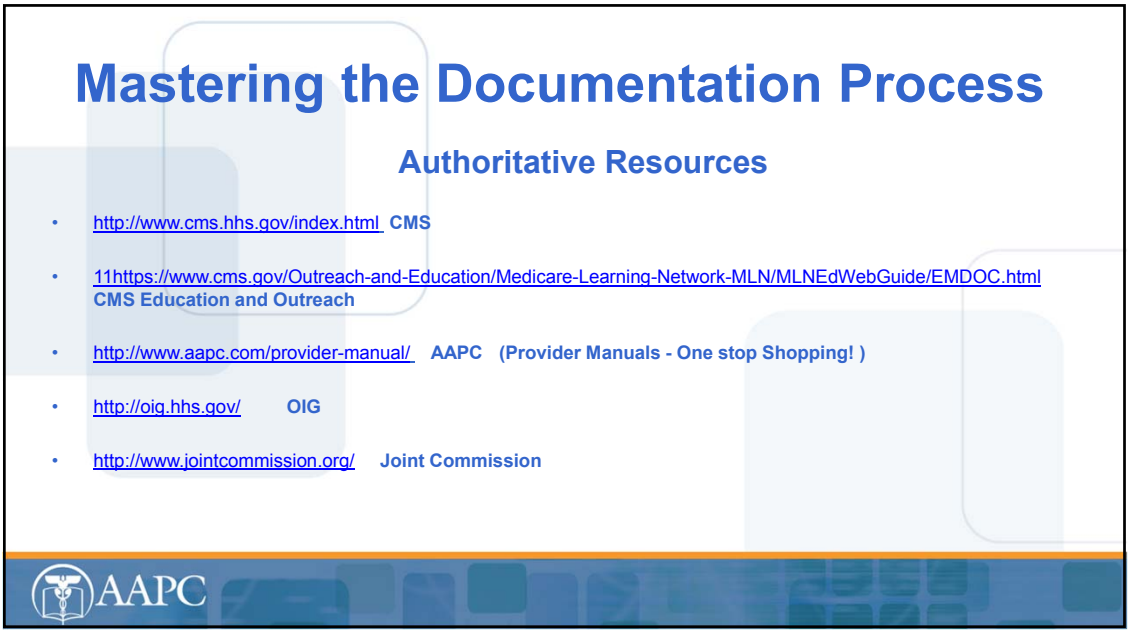
- Fraud $1.5 million dollar settlement, Mississippi
  - Qui-tam lawsuit
  - Alleged that the hospital billed under the physician provider numbers when, in fact, the services were rendered by nurses, rather than physicians.
  - The nursing services are billed at a lower rate than physician services. So the hospital billed under the physician provider ID# to achieve higher rate of reimbursement rate.

AAPC


Mastering the Documentation Process
Medical Necessity
• Deliberate
• Many cases of abusive billing are brought against providers on a daily basis because of documentation issues…
– Abusive?
AAPC


Mastering the Documentation Process
Authoritative Resources
• CMS
• AMA
• AAPC
• ICD-9 Official Guidelines
• Medical policies by private payers
• Hospital policies
AAPC





Mastering the Documentation Process

Authoritative Resources

- https://www.novitas-solutions.com/index.html (**Highmark Medicare Services)**
- http://www.gpo.gov/fdsys/browse/collection.action?collectionCode=FR **Federal Register**
- http://www.cms.hhs.gov/Regulations-and-Guidance/Manuals/Internet-Only-Manuals-IOMs.html **CMS Internet Manuals**

AAPC

Mastering the Documentation Process

Authoritative Resources

- One of the most authoritative resources is the Code of Federal Regulation,
  - (CFR) Title 42: Public Health Section 410
- http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=cf0dac0980199298a0d291486f42125&rgn=div5&view=text&node=42:2.0.1.2.10&idno=42
- Statutes the federal government imposes for Supplemental Medical Insurance Benefits

AAPC

Mastering the Documentation Process

Authoritative Resources

Table of Contents

- Subpart B- Medical and Public Health Services.
- Subpart C- Home Health Services under SMI
- Subpart D- Comprehensive Outpatient Rehabilitation Facility (CORF)
- Subpart E- Community Mental Health Services. Providing Partial Hospitalization services.

AAPC

Mastering the Documentation Process

Authoritative Resources

Example

- Subpart B is “Medical and Health Services”
- This contains sections § 410.10 - § 410.78
- 78 topics concerning health care services within subpart B.

AAPC

Mastering the Documentation Process

Authoritative Resources

- § 410.20 Physicians' services
- § 410.21 Limitations on services of a Chiropractor
- § 410.22 Limitations on services of an optometrist
- § 410.23 Screening for glaucoma: Conditions for and limitations on coverage
- § 410.26 Services and supplies incident to a physician's professional services: Conditions

AAPC

Mastering the Documentation Process

Authoritative Resources

Section § 410.34

Mammography services: Conditions for and limitations on coverage.

- A personal history of a (biopsy-proven) benign breast disease.
- The interpretation of the results of the procedure.
- The clear distinction within the record of the type of mammogram being ordered.
- If the order is for a screening mammogram the age of the patient and the date of the last mammogram is important documentation.

AAPC

Mastering the Documentation Process

Authoritative Resources

- § 410.20 Physicians' services
- § 410.21 Limitations on services of a Chiropractor
- § 410.22 Limitations on services of an optometrist
- § 410.23 Screening for glaucoma: Conditions for and limitations on coverage
- § 410.26 Services and supplies incident to a physician's professional services: Conditions

AAPC

Mastering the Documentation Process

Authoritative Resources

Section § 410.34

Mammography services: Conditions for and limitations on coverage.

- A personal history of a (biopsy-proven) benign breast disease.
- The interpretation of the results of the procedure.
- The clear distinction within the record of the type of mammogram being ordered.
- If the order is for a screening mammogram the age of the patient and the date of the last mammogram is important documentation.

AAPC

Educating the Clinicians

- Effective Education
  - Promote change
- Respect for provider
- Establish integrity
- Use current accurate authoritative information
- It's not personal
- Know your provider and how they respond best
  - Verbal
  - Visual
  - Kinetics

AAPC

Educating the Clinicians

- No abstracts
- Use meaningful data when training
- Equate to loss in revenue
- Equate to increase risk
  - Fines
  - Penalties
  - Claim denial
  - Pre-payment reviews
  - Recoupment of payments

AAPC

The Impact of ICD-10 on Documentation

October 1, 2014

AAPC

Chapter 5
The Impact of ICD-10 on Documentation

ICD-9-CM	ICD-10-CM
3-5 characters	3-7 characters
13,000 codes	69,000 codes
1st character can be • Numeric • E • V	1st character is • Alpha 2-3 characters • Numeric 4-7 characters • Alpha or • Numeric
Limits space for new codes	Ability to expand
Lacks detail	Add specificity
Lacks laterality	Demonstrates right and left, etc.

AAPC

The Impact of ICD-10 on Documentation

Example 1:
Carpal Tunnel Syndrome
ICD-9-CM

There is one 4-character code for Carpal Tunnel Syndrome in ICD-9-CM.
√**4th** **354** Mononeuritis of upper limb and
Mononeuritis multiplex
354.0 Carpal tunnel syndrome
(Modifiers are used to designate laterality).

AAPC

The Impact of ICD-10 on Documentation

Example 1:
Carpal Tunnel Syndrome
ICD-10-CM
In ICD-10-CM - laterality will be incorporated
√**4th** **G56** Mononeuropathies of upper limb
√**5th** **G56.0** Carpal tunnel syndrome
G56.00 Carpal tunnel syndrome, **unspecified** upper limb
G56.01 Carpal tunnel syndrome, **right** upper limb
G56.02 Carpal tunnel syndrome, **left** upper limb

AAPC

The Impact of ICD-10 on Documentation

Combination Codes

- The ICD-10-CM also expands on the use of combination codes
- Single codes that report more in-depth details of a diagnosis
- Eliminates the need for reporting two or three additional codes to report the same details of the condition
  - A diagnosis with an associated secondary process
  - A diagnosis with an associated complication

AAPC

The Impact of ICD-10 on Documentation

Example 2:

Pressure ulcer of the ankle

ICD-9-CM

Pressure ulcer of the ankle

- 707.06
  - ICD-9-CM instructs coders to use an additional code to report the stage of the ulcer.
- 707.21 Pressure ulcer stage 1
- Laterality is designated by the addition of the right or left modifier. (RT, LT)

AAPC

The Impact of ICD-10 on Documentation

- ICD-10-CM
- The first three characters identify the condition of **Pressure ulcer** L89
- The fourth character identifies the anatomical site L89.5 Pressure ulcer **of ankle**
- The fifth demonstrates laterality:
- √ 5th, in this case the 5th character demonstrates laterality
- 0 unspecified ankle
- 2 right ankle
- 3 left ankle
- The sixth character is the designation of the stage of the ulcer.
- √ 6th
- 0 unstageable
- 1 Stage 1
- 2 Stage 2
- 3 Stage 3
- 4 Stage 4
- 9 Unspecified stage

AAPC

The Impact of ICD-10 on Documentation

Potential Categories of Risk

- Educate providers

  Diabetes Mellitus (DM)

  One of the largest additions in ICD-10-CM

  There are greater than> 200 codes for DM

- **DM codes in ICD-10-CM are combination codes include:**
  - Type of diabetes mellitus
  - Body system affected
  - Complications of that body system

AAPC

The Impact of ICD-10 on Documentation

- Five DM categories in ICD-10-CM demonstrate the "type"
  - E08 Due to an underlying condition
  - E09 Drug or chemical induced
  - E10 Type I DM
  - E11 Type 2 DM
  - E13 Other specified DM
  - E14 Unspecified diabetes mellitus

AAPC

The Impact of ICD-10 on Documentation

Example: E11 "type" Type II DM

E11. Type 2 diabetes

Excludes1:

DM due to underlying condition (E08.-)
Drug or chemical induced DM (E09.-)
Gestational diabetes (O24.4-)
Neonatal DM (P70.2)
Post pancreatectomy DM (E13.-)
Post-procedural DM (E13.-)
Secondary DM NEC (E13.-)
Type 1 DM (E10.-)

AAPC

The Impact of ICD-10 on Documentation

E11.**0** Type 2 diabetes mellitus with **hyperosmolarity**

E11.0**0** Type 2 diabetes mellitus with hyperosmolarity **without** nonketotic hyperglycemic-hyperosmolarity **coma** (NKHHC)

E11.0**1** Type 2 diabetes mellitus with hyperosmolarity **with coma**

E11.**2** Type 2 diabetes mellitus **with kidney complications**

E11.2**1** Type 2 diabetes mellitus with **diabetic nephropathy**

E11.2**2** Type 2 diabetes mellitus with **diabetic chronic kidney disease**

***Use additional** code to identify stage of chronic kidney disease (N18.1-N18.6)*

E11.2**9** Type 2 diabetes mellitus with **other diabetic kidney complication**

AAPC

The Impact of ICD-10 on Documentation

E11.**3** Type 2 diabetes mellitus with ophthalmic complications

E11.3**1** Type 2 diabetes mellitus with unspecified diabetic retinopathy

E11.311 Type 2 diabetes mellitus with unspecified diabetic retinopathy with macular edema

E11.319 Type 2 diabetes mellitus with unspecified diabetic retinopathy without macular edema

AAPC

The Impact of ICD-10 on Documentation

Injuries

Chapter 19: (S00-T88)
Injury, poisoning, and certain other consequences of external cause

- Seventh character the type of encounter
- 7th character, required, or as notes in tabular list instruct
- The 7th data field always
- X must be used to fill in the empty characters

AAPC

The Impact of ICD-10 on Documentation

7th Character

- **"A" Initial encounter**
  - Surgical treatment
  - Emergency department encounter
  - Evaluation and treatment by a new physician
- **"D" Subsequent encounter**
  - Healing or recovery phase
  - Cast change or removal
  - Removal of external or internal fixation device
  - Medication adjustment,
  - Other aftercare and follow up visits following treatment of the injury or condition.

AAPC

The Impact of ICD-10 on Documentation

7th Character

- **"S" Sequela encounter**
  - complications or conditions that arise as a direct result of a condition
  - such as scar formation after a burn. The scars are sequela of the burn

When using 7th character "S", it is necessary to use both the injury code that precipitated the sequela and the code for the sequela itself. The "S" is added only to the injury code, not the sequela code. The 7th character "S" identifies the injury responsible for the sequela. The specific type of sequela (e.g., scar) is sequenced first, followed by the injury code.

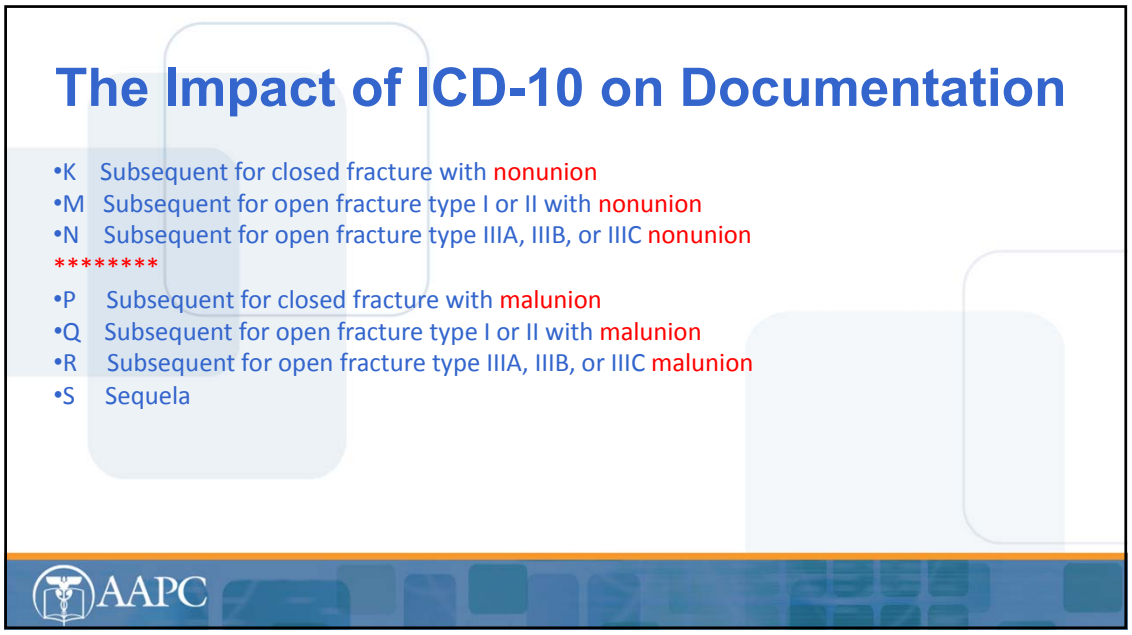
AAPC

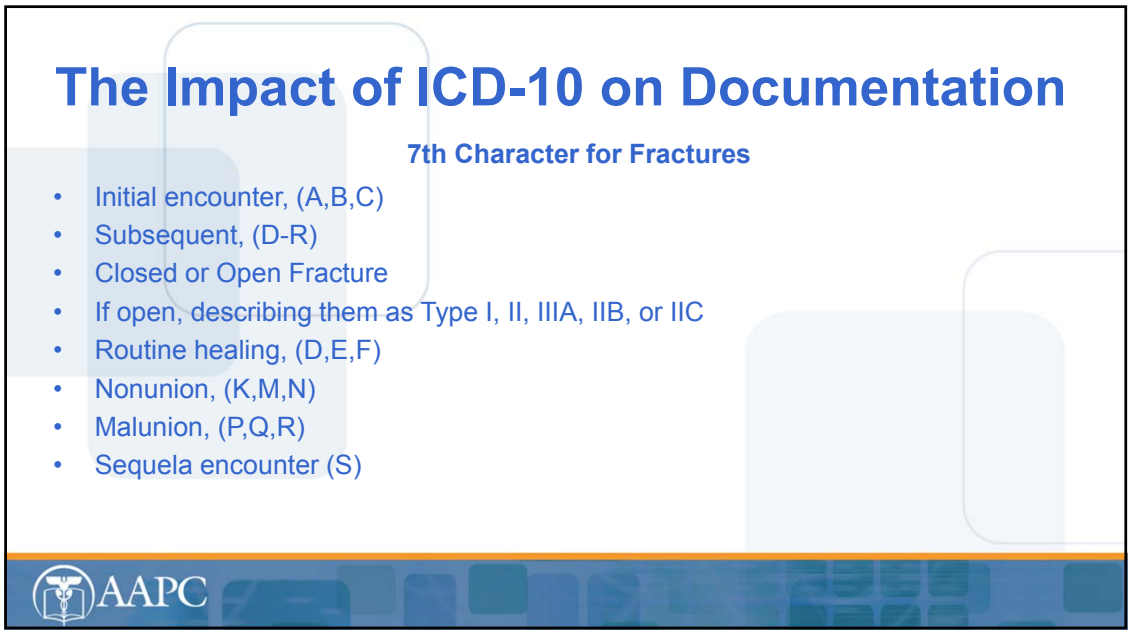
The Impact of ICD-10 on Documentation

7th Character for Fractures

- A Initial encounter closed fracture
- B Initial encounter for open fracture type 1 or II
- C Initial encounter for open fracture type IIIA, IIIB, or IIIC
- D Subsequent for closed fracture with routine healing
- E Subsequent for open fracture type I or II with routine healing
- F Subsequent for open fracture type IIIA, IIIB, or IIIC with routine healing
- ********
- G Subsequent for closed fracture with delayed healing
- H Subsequent for open fracture type I or II with delayed healing
- J Subsequent for open fracture type IIIA, IIIB, or IIIC with delayed healing
- *********
- K Subsequent for closed fracture with nonunion

AAPC





The Impact of ICD-10 on Documentation

7th Character for Fractures

S72.322A Displaced transverse fracture of shaft of left femur, initial encounter for closed fracture

S72. The three character category describes the *ANATOMICAL SITE* of the fracture. ***(FEMUR)***

S72.**3** The fourth Character (3) describes the ***SHAFT*** of the femur. (The specific location on the femur.)

S72.3**2** The fifth character (2) describes the type of fracture, being ***DISPLACED TRANSVERSE***

S72.322**2** The sixth character (2) describes the ***LEFT*** femur

S72.322**A** The seventh character (A) describes ***INITIAL ENCOUNTER FOR CLOSED*** **fracture**

- This demonstrates that each character added providers more information about the patient condition and the type of encounter.

AAPC

The Impact of ICD-10 on Documentation

Musculoskeletal Conditions Chapter 13

Chapter 13 (M00-M99)

- Distinction between a traumatic injury and a degenerative condition.
  - Pain
  - Arthritis
  - Any condition degenerative in nature

AAPC

The Impact of ICD-10 on Documentation

Pregnancy

Example:

088. Obstetric **embolism**

088.**1 Amniotic fluid** embolism

088.1**1** Amniotic fluid embolism **in Pregnancy**

088.11**1** Amniotic fluid embolism in Pregnancy **first trimester**

088.11**2** Amniotic fluid embolism In Pregnancy **second trimester**

Identification of fetus in complication codes.

064.0xx2 Obstructed labor due to incomplete rotation of fetal head, **fetus 2**

AAPC

The Impact of ICD-10 on Documentation

Neoplasm

C92.00 Acute myeloblastic leukemia **NOT having achieved remission**

C92.01 Acute myeloblastic leukemia **in Remission**

C92.02 Acute myeloblastic leukemia **in Relapse**

Personal history

Z85.6 Personal history leukemia

Conditions classifiable to C91-C95

Excludes: *Leukemia in remission C91.0-C95.9 with 5th character 1*

AAPC

The Impact of ICD-10-PCS Documentation

Requires time frames added to certain codes

Respiratory/ventilator for:

- Less than 24 consecutive hours
- 24-96 consecutive hours
- More than 96 consecutive hours

AAPC

The Impact of ICD-10- PCS Documentation and Terminology

ICD-9	ICD-10
Amputation	Detachment
Amniocentesis	Aspiration/Drain
Arthroscopy	Inspection or Endoscopic Approach
Cesarean Section	Extraction of the Products of Conception
Closed reduction	Reposition
Debridement	Excision, Extraction Irrigation, Extirpation
Radical Mastectomy	Resection RT,LT -Bilateral
Subtotal Mastectomy	Excision
Tonsillectomy	Resection of Tonsils

AAPC

The Impact of ICD-10

Summary

- Greater specificity with diagnosis and procedure coding
  - Laterality
  - Episode of care
  - New terminology
  - Details of body parts
  - Approach
  - Methodology
  - Devices used in procedures
  - Other qualifying information

AAPC

Coding and Abstracting

- *"Innocent billing errors are a significant drain on the Federal health care programs. All parties (physicians, providers, carriers, fiscal intermediaries, Government agencies, and beneficiaries) need to work cooperatively to reduce the overall error rate. Finally, it is reasonable for physicians (and other providers) to ask: what duty do they owe the Federal health care programs? The answer is that all health care providers have a duty to reasonably ensure that the claims submitted to Medicare and other Federal health care programs are true and accurate.*

- *The OIG continues to engage the provider community in an extensive, good faith effort to work cooperatively on voluntary compliance to minimize errors and to prevent potential penalties for improper billings before they occur.*

  Federal Register / Vol. 65, No. 194

AAPC

Coding and Abstracting

The details facilitates the abstracting process of coding!

- The coder may have to report the lowest valued code because the details in the report do not allow for a higher level.
- Reporting the lowest level of repair because the length and/or depth of a repair are not reported in the record
- The coder's options are to code the CPT® code describing the shortest length (lowest value) or
  - hold the claim until the provider dictates an addendum with enough details to code correctly.

AAPC

Coding and Abstracting

Example in the work book

Integumentary

A patient presents to the ER with multiple lacerations following a bicycle accident. The provider documents the repair of a superficial laceration on the patient's left forearm and an 11 cm laceration on the patient's left calf. The provider meticulously debrides the laceration on the lower extremity of all foreign debris and devitalized tissue, thoroughly irrigated the wound with antibiotic solutions and closed with 2-0 Vicyl suture. Once closures were complete sterile dressings are applied and the patient was instructed on wound care and told to follow-up with their PCP.

- The repair codes are described as: Simple, Intermediate, and Complex repairs.
- Simple repairs 12001-12021
- Intermediate repairs 12031-12057
- Complex repairs 13100-13160

AAPC

Coding and Abstracting

Example in the work book

Integumentary

1) Bundled into the ER visit if closed with surgical glue or butterfly strips
2) Code as a simple repair with code 12001
3) Knowing that the lower extremity wound was contaminated with foreign debris, one may reason that the upper extremity could have been contaminated as well.

This could change the code category to an intermediate closure of a contaminated superficial wound. Not knowing the length we would have to code 12031.

AAPC

Coding and Abstracting

Example in the work book

Integumentary

For the lower extremity, because the details were not complete, the coder has several scenarios that could be possible.

1) Code as an intermediate repair of an 11 cm superficial contaminated wound. Code 12034
2) Code as a complex repair of an 11 cm intermediate contaminated wound. Codes 13121 and code 13122
3) If the forearm is an intermediate repair of a superficial contaminated wound, and the lower extremity is an intermediate repair of a superficial contaminated wound the coder would have to add the length of both wounds together and select the code from codes 12034 – 12037.

AAPC

Coding and Abstracting

Example in the work book

Integumentary

- Demonstrates the need for complete, detailed documentation.
  - ER coding is outsourced, or the
  - Coding department is remote.
  - Holding the claim may cause extended delay
- Discussion point*

Provider completed a billing sheet with code 12005

  - The documentation is not specific that the laceration was 12.6 and 20 cm long
  - The coder still cannot process/bill the claim
    - A billing sheet is not sufficient documentation for code selection.
    - The medical record must stand alone and provide the details of the procedures.
    - This example impacts code selection and compliance with concise documentation

AAPC

Coding and Abstracting

Example in the work book

Example: 1

- The patient presents to the office with severe pain in the right lower leg. The provider documented suspected meniscal tear as the diagnosis and sent it to the staff for data entry.

AAPC

Coding and Abstracting

Example in the work book

Example: 2

- The patient presents to the office with severe pain in the right lower leg. The 55-year-old male who appears to be WDWN, however, is somewhat **anxious** and concerned that he "messed up his knee really bad." His pain is an **8 on a scale from 1-10**. He reports that he **fell down a flight of stairs last night**. He experienced **immediate throbbing pain and swelling** in the right knee. He is **unable to bear weight** on the leg and is having **difficulty walking.** He has a ***gash*** on his **left leg.** X-rays reveal no acute bony abnormality to either knee. He has ***restricted range of motion*** due to his pain. ***Sensation*** in the lower extremities is intact. ***Distal pulses*** are strong with good capillary refill.

AAPC

Coding and Abstracting

Example in the work book

- **Example: 2**
- Detail of the "gash" on the left leg ?
- What did the provider do concerning the "gash"?
- Was this repaired in the office?
- How deep was the "gash"?
- Were X-rays performed in the provider's office during this encounter?
- Has the patient had prior treatment for this injury ?
- It is not clear if the patient brought the X-rays with him?
- If X-rays were performed in the office, What and how many views?
- It is inferred by the word "either" knee that both knees were X-rayed?

AAPC

Coding and Abstracting

- **Example: 3**

The patient presents to the office with severe pain in the right lower leg. He is a new patient to the office. He is a 55 year old male who appears to be wdwn; (ROS) however, is somewhat anxious and concerned that he "messed up his knee really bad." His pain is an 8 on a scale from 1-10. (HPI)He reports that he fell down a flight of stairs last night. (HPI) He experienced immediate throbbing pain and swelling (HPI). He is unable to bear weight on the right leg. (HPI) and is having difficulty walking. He denies loss of consciousness after the fall and any dizziness (ROS) prior to the fall. He states he just slipped, lost his balance, and fell down the steps. He has no other musculoskeletal complaints.(ROS) He has 6 cm laceration on his LEFT leg involving the subcutaneous tissue only.(EXAM) He has a history of diabetes, which is well controlled.(ROS) He in a non-smoker. He is employed as an inspector with the county fire department. (Social Hx.) His medical history is reviewed and is scanned into the record. There are no pertinent findings on his ROS other than those just mentioned. His RIGHT leg shows no evidence of lacerations or bruising. He has restricted range of motion due to his pain in the right, knee. There are no signs of instability or muscle weakness on the right. He is tender on the anterior and medial joint.

ROM, muscle strength and joint stability on the LEFT is normal. Sensation in the lower extremities is intact. Distal pulses are strong with capillary refill < 3 seconds bilaterally. The laceration was cleaned and sutured closed with local infiltration of 4cc of 1.0 % Xylocaine without difficulty.

X-rays taken in the office today to include AP and Lateral views of the right and left knee reveal no acute bony abnormality. Due to the clinical findings I am ordering an MRI of the right knee. He is not allergic to any drugs. He has taken Lortab before without in complications and it seemed to relieve his pain. He is given Lortab 7.5 mg to take 1-2 tabs every four to six hours as needed for pain.

He is sent to PT for crutch training, instructed in "RICE". We will follow-up with him as soon as we have the MRI. He understands the instructions given and will call the office if he has any problems prior to his next appointment. He is given a note, not to return to work for at least 5 days. We should have the results of the MRI by then.

AAPC

Coding and Abstracting

Example 3 - History Detailed or Comprehensive

HPI:	ROS	PFS
Severity: pain 8 (1-10)	Neurological: denies dizziness, or loss of consciousness	Employment
Timing: last night	c/o no other M/S problems	Non-smoker
Quality: throbbing	Endocrine: Diabetes	
S&S: Swelling	Constitutional: WDWN	
M- F or Context: Unable to bear weight		

AAPC

Coding and Abstracting

Example: 3 Exam - Detailed 1995

- **4 organ systems**,
  - Cardiovascular
  - Neurological
  - Integumentary
  - Musculoskeletal
- **2 body areas**
  - Right lower extremity
  - Left lower extremity

- **Right lower extremity:**
  - Skin: Negative for lacerations or bruising
  - ROM: Limited due to pain
  - Joint stability: Negative for instability
  - Muscle weakness: Negative
  - Palpation:- Tender anterior, medial joint
  - Neurological: Normal sensation
  - Cardiovascular:- Normal distal pulse
- **Left Lower extremity:**
  - ROM: Normal
  - Joint stability: Normal
  - Muscle Strength: Normal
  - Skin: 6cm laceration superficial laceration.
  - Neurological: Normal sensation (already counted for right)
  - Cardiovascular: Normal distal pulse (already counted for Right)

AAPC

Coding and Abstracting

- **Example: 3 MDM**

Moderate

New patient with additional work up	4	Diagnosis Management
Acute injury	Mod	Risk
RX drug management	Mod	Risk
Order x-ray	1	Data

99203 Detailed Hx (minimum)
99203 Exam Detailed 1995 (99202 for 1997guidelines)
99204 Moderate MDM

99203 -25 (1995)
99202 -25 (1997)
12001
73560-50

AAPC

Coding and Abstracting

- **Example: 3**

- **Diagnoses**

1) 719.46	Pain in the knee joint
2) 719.7	Difficulty walking
3) 891.0	Open wound without mention of complication
4) E880.9	Fall from stairs or steps

AAPC

Coding and Abstracting

Example: 3 The patient centered note !

- The HPI and ROS clearly indicate the provider questioned the patient about the accident.
- The provider was concerned about other conditions that could have caused the accident or happened as the result of the accident.
- He questioned the patient about his diabetes noting this to be well controlled. Diabetes impacts healing and may play a role in the plan of care.
- The provider is managing his pain with Rx management, there is evidence he asked the patient about any previous allergies or complications with and the effectiveness of taking Lortab.
- He is sending him for crutch training.

AAPC

Coding and Abstracting

Example: 3 The patient centered note !

- Giving the patient instructions concerning rest, ice, compresses, and elevation to assist with pain control.
- The provider questioned the patient about his work activities. He made decisions concerning his ability to work due to his pain level, the medication he was providing and the fact that he would be non weight bearing.
- He also provided the patient with a note for his work status.
- He noted the patient understood his instructions and encouraged him to call the office if he has any problems.
- If support staff or another provider reviews the record, they would have a very clear understanding of the patient's complaint, condition, and the provider's, plan of care.

AAPC

Coding and Abstracting

CODING RISKS THE OIG's POINT OF VIEW

The following risk areas associated with billing have been among the most frequent subjects of investigations and audits by the OIG:

- *Billing for items or services not rendered or not provided as claimed;*
- *Double billing resulting in duplicate payment;*
- *Submitting claims for equipment, medical supplies and services that are not reasonable and necessary;*

Definition Medical Necessity

42 U.S.C. 1395i (a)(1)(A) ("no payment may be made under part A or part B [of Medicare] for any expenses incurred for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of the malformed body member"

- *Billing for non-covered services as if covered;*
- *Knowing misuse of provider identification numbers, which results in improper billing;*
- *Unbundling (billing for each component of the service instead of billing or using an all-inclusive code);*
- *Failure to properly use coding modifiers;*
- *Clustering;*
- *Up coding the level of service*

AAPC

Chapter 7
Implementation of a CDI Plan

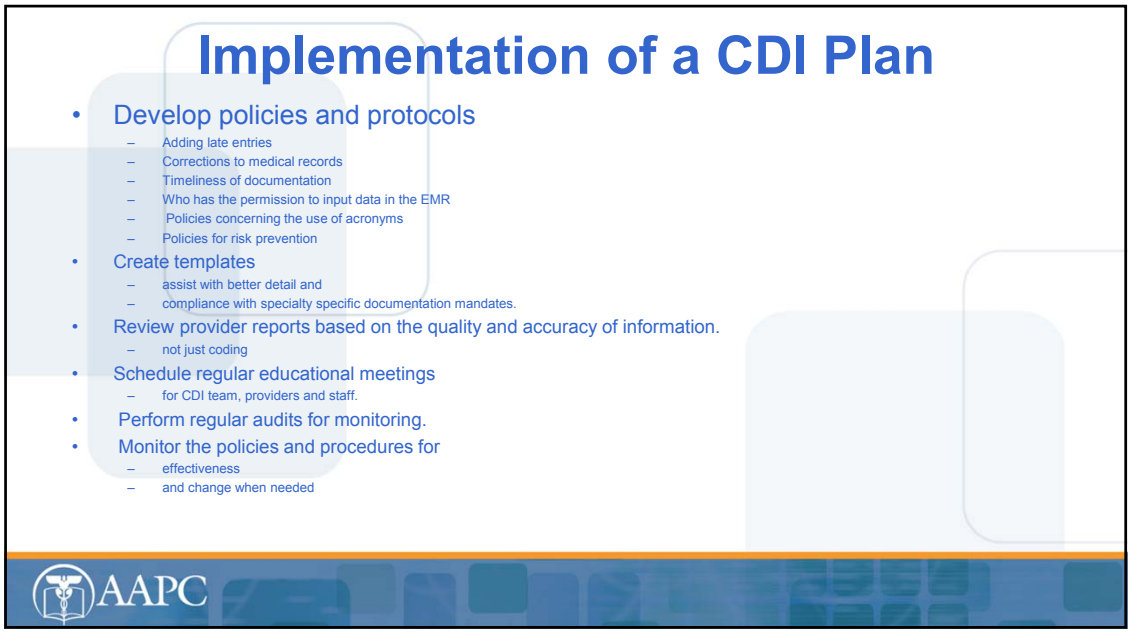
- Assign a physician advocate and the compliance officer to assist.
- Employ the coding and / or auditor to manage aspects of the documentation improvement process associated to coding, billing, and reimbursement. (This teamwork utilized the skills and expertise of the coding and auditing professionals when the CDI process overlaps).
- Involve all departments that play a role in the documentation.
- Assign one individual in each department.
- Identify the practice / facility needs within each department.
- Authoritative guidelines and instructions, work greatest risk first.

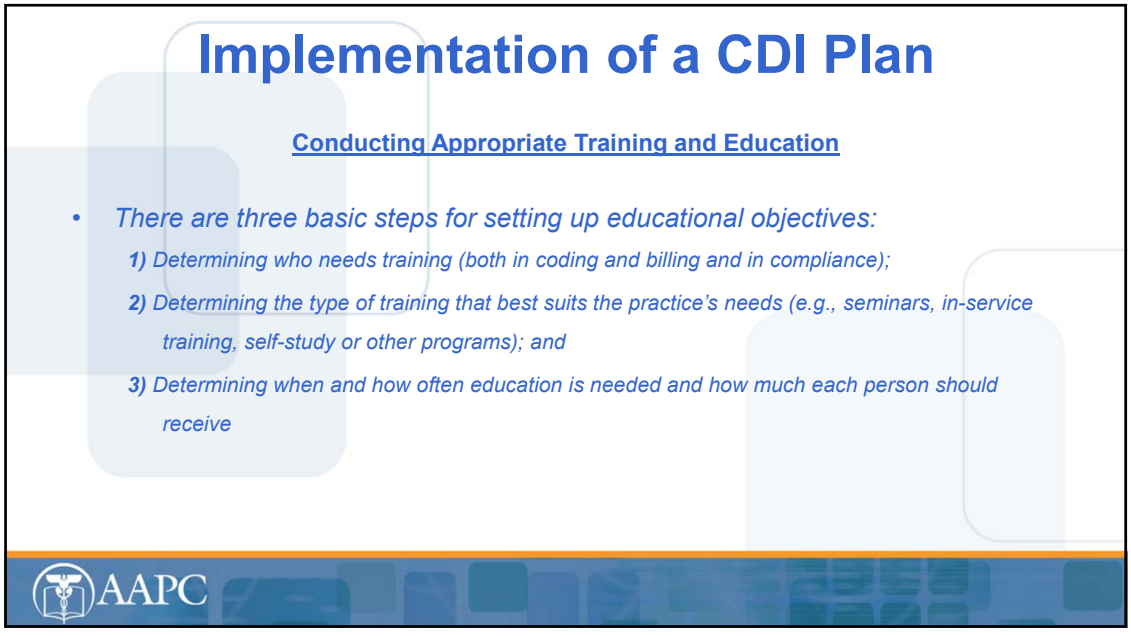
AAPC

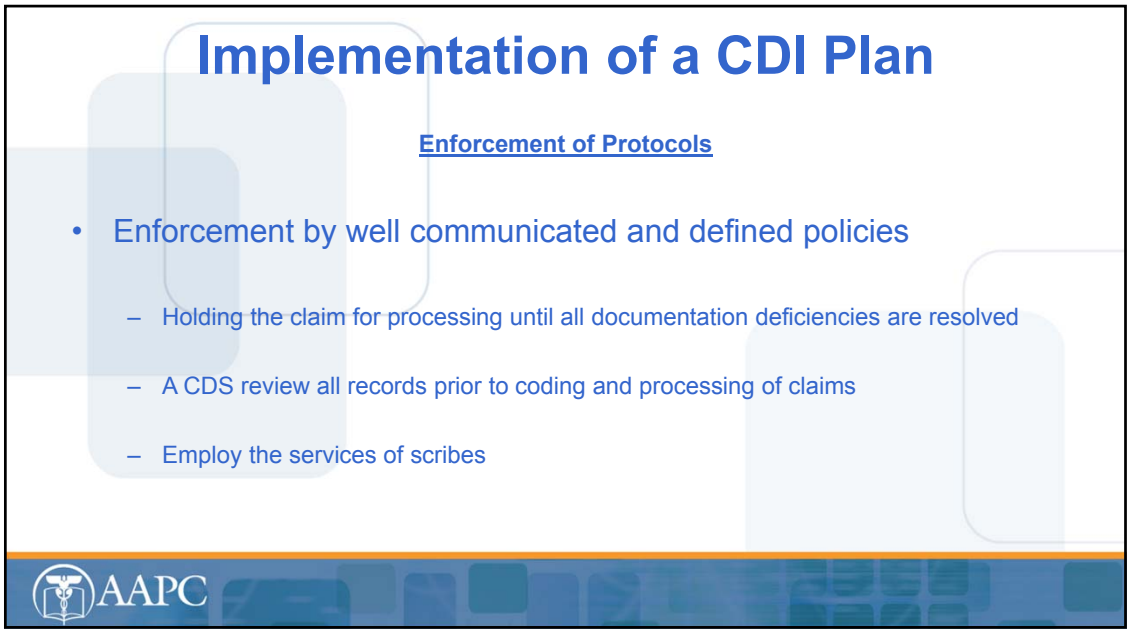
Implementation of a CDI Plan

- Assign a physician advocate and the compliance officer to assist
- Employ the coding and / or auditor to manage aspects of the documentation improvement process associated to coding, billing, and reimbursement. (This teamwork utilized the skills and expertise of the coding and auditing professionals when the CDI process overlaps)
- Involve all departments that play a role in the documentation
- Assign one individual in each department
- Identify the practice / facility needs within each department.
- Authoritative guidelines and instructions, work greatest risk first.

AAPC






Implementation of a CDI Plan
Enforcement of Protocols
• Enforcement by well communicated and defined policies
– Holding the claim for processing until all documentation deficiencies are resolved
– A CDS review all records prior to coding and processing of claims
– Employ the services of scribes
AAPC