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Meet the Presenter…

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Peak Performance Physicians, LLC

On the topic:
Document, Document, Document
Documentation

• ICD-10-CM Draft Official Guidelines for Coding and Reporting

• the importance of consistent, complete documentation in the medical record cannot be over emphasized.

OIG Work Plan 2013

• Physicians—Error Rate for Incident-To Services Performed by Non-physicians ................................................................. 25
• Physicians—Place-of-Service Coding Errors .................................. 25
• Evaluation and Management Services—Potentially Inappropriate Payments in 2010................................................................. 25
• Evaluation and Management Services—Use of Modifiers During the Global Surgery Period ...................................................... 25
OIG Work Plan 2015

- Outpatient evaluation and management services billed at the new-patient rate ......................................................... 5
- Nationwide review of cardiac catheterizations and endomyocardial biopsies .......................................................... 5
- Payments for patients diagnosed with kwashiorkor ..................... 5

Why documentation is important?

- .... It WAS a way for you to communicate with yourself
- .... It BECAME a way to communicate with your colleagues
- .... It IS the way to communicate with Payors
Why Coding?

- ... the only way you communicate with Payors is numbers
  - CPT Codes report what you did
  - ICD 9/10 Codes report why you did it.

ICD 10 Documentation

- Complexity of ICD 10
  - Were 15,000 ICD 9 Codes
  - Are 67,000 ICD 10 Codes
    - 28% of the new codes deal with laterality

- Largest Most complicated Hospital uses 800 codes
- Average Hospital (150 beds) uses 300 codes
- Medical Practices 80 codes
### ICD 9 vs ICD10

<table>
<thead>
<tr>
<th>ICD 9</th>
<th>ICD 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialty Driven</td>
<td>Anatomical</td>
</tr>
<tr>
<td>All Numbers</td>
<td>Alpha and Numeric</td>
</tr>
<tr>
<td>5 maximum</td>
<td>7 maximum</td>
</tr>
<tr>
<td>No placeholders</td>
<td>Placeholders</td>
</tr>
<tr>
<td>733.95 – Stress Fracture of other bone</td>
<td>M84.30xA -- Stress Fracture unspecified site</td>
</tr>
</tbody>
</table>

### Unspecified Codes

But will they ask for additional information?

**Hint: Laterality**

- If the code does not have a bi-lateral code and the condition is bi-lateral, then assign separate codes for both left and right

- **Documentation:** Location, Location, Location
  - The physician or staff, must begin documenting (correctly) Left, Right or bi-lateral.

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**Road to 10** ([http://www.roadto10.org](http://www.roadto10.org))
Road to 10

Primer for Family Practice Clinical Documentation Changes

Specifying an anatomic location and actually being in the patient’s clinic is a matter that you should always keep in mind. This detail reflects your physician’s and other team members’ training and what they pay attention to. It is a matter of ensuring the information is captured in your documentation.

In ICD-10, there are three main categories of changes:

- **Terminology Changes**
- **Organizational Changes**
- **Increased specificity**

User Guide should be in the generation of ICD-10 codes to ensure the addition of specificity (e.g., right, left, anterior, superficial, etc.) for other conditions that are not otherwise evaluated the clinically pertinent anatomic site.

Documentation

3. **DIABETES MELLITUS, HYPOGLYCEMIA AND HYPERGLYCEMIA**

**Increased Specificity**

The diabetes mellitus codes are combination codes that include the type of diabetes mellitus, the body system affected, and the complications affecting the body system.

When documenting diabetes, include the following:

1. **Type**
   - e.g., Type 1 or Type 2 diabetes, drug or chemical induced, due to underlying condition, gestational
2. **Complications**
   - What if any other body systems are affected by the diabetes condition? e.g., foot ulcer related to diabetes mellitus
3. **Treatment**
   - Is the patient on insulin?

A second important change is the concept of "hypoglycemia" and "hyperglycemia." It is now possible to document and code for these conditions without using "diabetes mellitus." You can also specify if the condition is due to a procedure or other cause.

The final important change is that the concept of "secondary diabetes mellitus" is no longer used; instead, there are specific secondary options.

**ICD-10 Code Examples**

- E08.65: Diabetes mellitus due to underlying condition with hypoglycemia
- E09.01: Drug or chemical induced diabetes mellitus with hyperglycemia with coma
- R73.9: Transient post-procedural hyperglycemia
- K91.9: Hypoglycemia, unspecified
Documentation

Documentation – Definition Change

1. ACUTE MYOCARDIAL INFARCTION (AMI)

Definition Change
When documenting an AMI, keep the following in mind:
1. Timeframe
   - An AMI is now considered "acute" for 4 weeks from the time of the incident.
2. Episode of care
   - ICD-10 does not capture episodes of care (e.g., initial, subsequent, sequela).
3. Subsequent AMI
   - ICD-10 allows coding of a new AMI that occurs during the 4 week "acute period" of the original AMI.

ICD-10 Code Examples
- E11.02  ST elevation (STEMI) myocardial infarction involving left anterior descending coronary artery
- E11.4  Non-ST elevation (NSTEMI) myocardial infarction
- E22.1  Subsequent ST elevation (STEMI) myocardial infarction

2. HYPERTENSION

3. ASTHMA

4. UNDERDOSING

5. DIABETES MELLITUS, HYPOGLYCEMIA AND HYPERGLYCEMIA

6. ABDOMINAL PAIN AND TENDerness
Major concepts of Documentation

- Medical Necessity
- Coding Guidelines
- Over Documentation
- Cut and Paste / Cloning
- Signature Guidelines
- New Patient vs. Established
- Consultations
- Regulatory Threats

Medical Necessity

- The overarching component of the payment system —
  
  - Notwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services which, except for items and services described in a succeeding subparagraph, are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member

- Not a Medical Concept – it is an Insurance Concept
- It is the easiest way to deny payment
Coding Guidelines

• For Medical Offices
  • 1995 Documentation Guidelines for Evaluation and Management Services
  • 1997 Documentation Guidelines for Evaluation and Management Services
    • The Centers for Medicare and Medicaid Services (CMS) has stated that providers can use either the 1995 or 1997 documentation guidelines, whichever is more advantageous to allow the level of service that is being billed. In choosing between the two sets of guidelines, the auditor must remember that only the criteria for the examination element is different. The history and medical decision-making elements remain the same, except for the permitted use of the status of chronic conditions as HPI in the 1997 documentation guidelines, but not in the 1995 documentation guidelines.
  • NOTE: Since you are converting to EHR, you are all using the 1997 Guidelines

Coding Auditor’s Guidelines

• Peak Performance Physicians, LLC uses the Audit Criteria (1995 or 1997) which ever is more favorable to the physician.

  
Over documentation

- Over documentation is the practice of inserting false or irrelevant documentation to create the appearance of support for billing higher level services. Some EHR technologies auto-populate fields when using templates built into the system. Other systems generate extensive documentation on the basis of a single click of a checkbox, which if not appropriately edited by the provider may be inaccurate. Such features can produce information suggesting the practitioner performed more comprehensive services than were actually rendered.

- CMS and Its Contractors Have Adopted Few Practices To Address Vulnerabilities in EHRs (OEI-01-11-00571), January 2014

Cut and Paste / Cloning

- *Copy-Pasting*. Copy-pasting, also known as cloning, enables users to select information from one source and replicate it in another location. When doctors, nurses, or other clinicians copy-paste information but fail to update it or ensure accuracy, inaccurate information may enter the patient’s medical record and inappropriate charges may be billed to patients and third-party health care payers. Furthermore, inappropriate copy-pasting could facilitate attempts to inflate claims and duplicate or create fraudulent claims.

- CMS and Its Contractors Have Adopted Few Practices To Address Vulnerabilities in EHRs (OEI-01-11-00571), January 2014
Signature Guidelines

- Attachment - Business Requirements
- Pub. 100-08
- Transmittal: 327
- Date: March 16, 2010
- Change Request: 6698
- SUBJECT: Signature Guidelines for Medical Review Purposes
- EFFECTIVE DATE: MARCH 1, 2010
- IMPLEMENTATION DATE: April 16, 2010

I. GENERAL INFORMATION
   - A. Background: Medicare claim review contractors (carriers, fiscal intermediaries (called affiliated contractors, or ACs), Medicare administrative contractors (MACs), the comprehensive error rate testing (CERT) contractor, and recovery audit contractors) are tasked with measuring, detecting and correcting improper payments in the fee for service (FFS) Medicare program. These contractors review claims and medical documentation submitted by providers.
   - The previous language in the PIM required a “legible identifier” in the form of a handwritten or electronic signature for every service provided or ordered. This CR updates these requirements and adds e-prescribing language.
   - B. Policy: Clarifies and updates various sections of the Program Integrity Manual.

Signature Stamps

- 6698.3
  - For medical review purposes, Medicare requires that services provided/ordered be authenticated by the author. The method used shall be a hand written or an electronic signature. **Stamp signatures are not acceptable.**
New vs Established Patient

**PATIENT TYPE**

- For purposes of billing for E/M services, patients are identified as either new or established, depending on previous encounters with the provider.
- A **new patient** is defined as an individual who has not received any professional services from the physician/non-physician practitioner (NPP) or another physician of the same specialty who belongs to the same group practice within the previous three years.
- An **established patient** is an individual who has received professional services from the physician/NPP or another physician of the same specialty who belongs to the same group practice within the previous three years.

Consultation Services

- **Effective for services furnished on or after January 1, 2010,** inpatient consultation codes (CPT codes 99251 – 99255) and office and other outpatient consultation codes (CPT codes 99241 – 99245) are no longer recognized by Medicare for Part B payment purposes. However, telehealth consultation codes (Healthcare Common Procedure Coding System G0406 – G0408 and G0425 – G0427) continue to be recognized for Medicare payment. Physicians and NPPs who furnish services that, prior to January 1, 2010, would have been reported as CPT consultation codes should report the appropriate E/M visit code in order to bill for these services beginning January 1, 2010.
Consultations

• The written or verbal request for consult may be made by a physician or other appropriate source and documented in the patient’s medical record by either the consulting or requesting physician or appropriate source. The consultant’s opinion and any services that were ordered or performed must also be documented in the patient’s medical record and communicated by written report to the requesting physician or other appropriate source.


Consultations

• Three “R’s”

  • REQUEST
  • RENDERING (of service)
  • REPORT (written)
Audits

• CMS and Fraud Detection With EHRs
  • CMS uses administrative and program integrity contractors to pay claims, identify improper Medicare payments, and investigate fraud. These contractors include Medicare Administrative Contractors (MACs), Zone Program Integrity Contractors (ZPICs), and Recovery Audit Contractors (RACs). MACs are responsible primarily for processing and paying Medicare claims. MACs collaborate with CMS and other contractors to ensure that they pay claims correctly. MACs also educate providers on appropriate billing methods and are responsible for detecting and deterring fraud.
  • ZPICs. ZPICs are responsible primarily for detecting and deterring Medicare fraud. ZPICs investigate providers that have filed potentially fraudulent claims by a variety of methods, including prepayment and postpayment reviews and onsite audits. They may also recommend that CMS or MACs revoke the billing privileges of providers.
  • RACs. RACs are responsible primarily for identifying and reducing Medicare improper payments by detecting and recouping improper payments made on claims of Medicare services.
  • MACs, ZPICs, and RACs rely on medical records in aspects of their program integrity work. The transition from paper records to EHRs may require these contractors to adjust their techniques for identifying improper payments and investigating fraud.
Return on Investment

- Health Care Fraud and Abuse Control Program
  - The return-on-investment (ROI) for the HCFAC program over the last three years (2011-2013) is $8.1 returned for every $1.00 expended. This is $2.7 higher than the average ROI for the life of the HCFAC program since 1997. Due to the fact that the annual ROI can vary from year to year depending on the number of cases that are settled or adjudicated during that year, DOJ and HHS use a three-year rolling average ROI for results contained in the report.

- The Department of Health and Human Services and The Department of Justice Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2013 – February 2014

False Claims Act

- The False Claims Act ("FCA") provides, in pertinent part, that:
  - (a) Any person who (1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government or a member of the Armed Forces of the United States a false or fraudulent claim for payment or approval; (2) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; (3) conspires to defraud the Government by getting a false or fraudulent claim paid or approved by the Government; . . . or (7) knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government,

- is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000, plus 3 times the amount of damages which the Government sustains because of the act of that person . . .

- (b) For purposes of this section, the terms "knowing" and "knowingly" mean that a person, with respect to information (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.
False Claims Act (cont’d)

- In sum, the False Claims Act imposes liability on any person who submits a claim to the federal government that he or she knows (or should know) is false. An example may be a physician who submits a bill to Medicare for medical services she knows she has not provided. The False Claims Act also imposes liability on an individual who may knowingly submit a false record in order to obtain payment from the government. An example of this may include a government contractor who submits records that he knows (or should know) is false and that indicate compliance with certain contractual or regulatory requirements. The third area of liability includes those instances in which someone may obtain money from the federal government to which he may not be entitled, and then uses false statements or records in order to retain the money. An example of this so-called “reverse false claim” may include a hospital who obtains interim payments from Medicare throughout the year, and then knowingly files a false cost report at the end of the year in order to avoid making a refund to the Medicare program.

Clustering

- Clustering; 19

19 This is the practice of coding/charging one or two middle levels of service codes exclusively, under the philosophy that some will be higher, some lower, and the charges will average out over an extended period (in reality, this overcharges some patients while undercharging others).

- OIG Compliance Guidelines
Areas of Concern

- Over documentation
- Cut and Paste
- Signatures
- New vs Established
- Consults
- Time vs coding -- how many patients can you see in a day…..

<table>
<thead>
<tr>
<th>E/M</th>
<th>History</th>
<th>Physical</th>
<th>MDM / Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>Problem focused</td>
<td>Problem focused</td>
<td>Straightforward</td>
</tr>
<tr>
<td>99202</td>
<td>Expanded</td>
<td>Expanded</td>
<td>Straightforward</td>
</tr>
<tr>
<td>99203</td>
<td>Detailed</td>
<td>Detailed</td>
<td>Low</td>
</tr>
<tr>
<td>99204</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
<td>Moderate</td>
</tr>
<tr>
<td>99205</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
<td>High</td>
</tr>
<tr>
<td>99211</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>99212</td>
<td>Problem focused</td>
<td>Problem focused</td>
<td>Straightforward</td>
</tr>
<tr>
<td>99213</td>
<td>Expanded</td>
<td>Expanded</td>
<td>Straightforward</td>
</tr>
<tr>
<td>99214</td>
<td>Detailed</td>
<td>Detailed</td>
<td>Moderate</td>
</tr>
<tr>
<td>99215</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
<td>High</td>
</tr>
</tbody>
</table>
Review of Systems (ROS)
Past Family Social History (PFSH)

• DG: A ROS and/or PFSH obtained during an earlier encounter does not need to be re-recorded if there is evidence that the physician reviewed and updated the previous information. This may occur when a physician updates his or her own record or in an institutional setting or group practice where many physicians use a common record. The review and update may be documented by:
  • describing any new ROS and/or PFSH information or noting there has been no change in the information; and
  • noting the date and location of the earlier ROS and/or PFSH.

• DG: The ROS and/or PFSH may be recorded by ancillary staff or on a form completed by the patient. To document that the physician reviewed the information, there must be a notation supplementing or confirming the information recorded by others.

Medical Decision Making

• Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option, which is determined by considering the following factors:
  • The number of possible diagnoses and/or the number of management options that must be considered;
  • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed; and
  • The risk of significant complications, morbidity, and/or mortality as well as comorbidities associated with the patient's presenting problem(s), the diagnostic procedure(s), and/or the possible management options.
Medical Decision Making

<table>
<thead>
<tr>
<th>TYPE OF DECISION MAKING</th>
<th>NUMBER OF DIAGNOSES OR MANAGEMENT OPTIONS</th>
<th>AMOUNT AND/OR COMPLEXITY OF DATA TO BE REVIEWED</th>
<th>RISK OF SIGNIFICANT COMPLICATIONS, MORTALITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Straightforward</td>
<td>Minimal</td>
<td>Minimal or None</td>
<td>Minimal</td>
</tr>
<tr>
<td>Low Complexity</td>
<td>Limited</td>
<td>Limited</td>
<td>Low</td>
</tr>
<tr>
<td>Moderate Complexity</td>
<td>Multiple</td>
<td>Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>High Complexity</td>
<td>Extensive</td>
<td>Extensive</td>
<td>High</td>
</tr>
</tbody>
</table>

**Table of Risk**

<table>
<thead>
<tr>
<th>LEVEL OF RISK</th>
<th>PRESENTING PROBLEM(S)</th>
<th>DIAGNOSTIC PROCEDURE(S)</th>
<th>MANAGEMENT OPTIONS SELECTED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>One or more self-limited or minor problems</td>
<td>Laboratory tests requiring interpretation, chest x-rays, EKGs, ultrasound</td>
<td>Over-the-counter drugs, non-surgical risk factors, physical therapy, occupational therapy, no fluids without advice</td>
</tr>
<tr>
<td>Moderate</td>
<td>Two or more self-limited or minor problems</td>
<td>Physical tests not under stress (e.g., thyroid tests, non-surgical imaging studies with minimal or no radiation)</td>
<td>Non-surgical risk factors, physical therapy, occupational therapy, no fluids without advice</td>
</tr>
<tr>
<td>High</td>
<td>One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment</td>
<td>Physical tests under stress (e.g., cardiac stress tests, diagnostic endoscopies with non-identified risk factors)</td>
<td>Non-surgical risk factors, physical therapy, occupational therapy, no fluids without advice</td>
</tr>
</tbody>
</table>

- Acute or chronic illnesses or injuries that place a high level of stress on the patient, such as a heart attack, stroke, acute MI, pulmonary embolism, severe respiratory distress, progressive severe dehydrated patients, psychosocial problems leading to self-harm or suicide, patients with severe sepsis, or patients with severe anemia
- An acute change in neurologic status (e.g., confusion, weakness, sensory loss)
MDM/Risk

- Medical Decision Making and Risk support Medical Necessity.
- Number and complexity of Diagnoses help support that Medical Necessity; however, only four diagnoses get reported to the Payors. Therefore, ranking the diagnoses is very important.
- The Primary Diagnosis is an outdated term in outpatient settings. The term was changed to First-listed Diagnosis some years ago, and it is the main condition treated or investigated during the relevant episode of outpatient (ambulatory) health care. Where there is no definitive diagnosis, the main symptom or sign, abnormal findings, or problem is reported as the first-listed diagnosis. The first-listed diagnosis is reported by physician offices, ambulatory care centers, outpatient hospital settings, and so on.
- The second, third and fourth go to support your complexity and Medical Necessity. Rank them wisely.

Contact

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305 205 7525
Questions?

• Get your questions answered on PMI’s Discussion Forum:
  http://www.pmimd.com/pmiForums/rules.asp