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On the topic:
Documentation Fundamentals
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Documentation Fundamentals

Developed and presented by:
Michael W. “Bill” Carbrey, MHA, CMC

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.
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

Guidelines for Medical Record Documentation

• Consistent, current and complete documentation in the medical record is an essential component of quality patient care. The 21 elements reflect a set of commonly accepted standard for medical record documentation. An organization may use the elements to develop standards for medical record documentation

• NCQA considers 6 of the 21 elements as core components to medical record documentation. **Core elements are indicated by an asterisk (*)**.

http://www.ncqa.org/Portals/0/PolicyUpdates/Supplemental/guidelines_medical_record_review.pdf
Guidelines for Medical Record Documentation

1. Each page in the record contains the patient's name or ID number.
2. Personal biographical data include the address, employer, home and work telephone numbers and marital status.
3. All entries in the medical record contain the author's identification. Author identification may be handwritten signature, unique electronic identifier or initials.
4. All entries are dated.
5. The record is legible to someone other than the writer.
6. * Significant illnesses and medical conditions are indicated on the problem list.
7. * Medication allergies and adverse reactions are prominently noted in the record. If the patient has no known allergies or history of adverse reactions, this is appropriately noted in the record.

8. * Past medical history (for patients seen three or more times) is easily identified and includes serious accidents, operations, and illnesses. For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, operations and childhood illnesses.
9. For patient 12 years and older, there is appropriate notation concerning the use of cigarettes, alcohol and substances (for patients seen three or more times, query substance abuse history).
10. The history and physicians identifies appropriate subjective and objective information pertinent to the patient's presenting complaints.
11. Laboratory and other studies are ordered, as appropriate.
Guidelines for Medical Record Documentation

12. *Working diagnoses are consistent with findings.
13. *Treatment plans are consistent with diagnoses.
14. Encounter forms or notes have a notation, regarding follow-up care or visits, when indicated. The specific time of return is noted in weeks, months or as needed.
15. Unresolved problems for previous visits are addressed in subsequent visits.
16. There is a review for under – or overutilization of consultants.
17. If a consultation is requested, there is a note from the consultant in the record.

18. Consultation, laboratory and imaging reports filed in the chart are initialed by the practitioner who ordered them, to signify review. (Review and signature by professionals other than the ordering practitioner do not meet this requirement.) If the reports are presented electronically or by some other method, there is also representation of review by the ordering practitioner. Consultation and abnormal laboratory and imaging study results have an explicit notation in the record of follow-up plans.
19. * There is no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure.
20. An immunization record (for children) is up to date or an appropriated history has be made in the medical record (for adults).
Guidelines for Medical Record Documentation

21. There is evidence that preventive screening and services are offered in accordance with the organization’s practice guidelines.
Health care payers may require reasonable documentation to ensure that a service is consistent with the patient’s insurance coverage and to validate:

- The site of service;
- The medical necessity and appropriateness of the Diagnostic and/or therapeutic services provided; and/or
- That the services furnished were accurately reported.

Date and legible identity of the observer;

- The diagnosis and treatment codes reported on the health insurance claim form or billing statement should be supported by documentation in the medical record.

To maintain an accurate medical record, document services during the encounter or as soon as practicable after the encounter.

A billing specialist or alternate source may review the provider’s documented services before submitting the claim to a payer. These reviewers may help select codes that reflect the provider’s furnished services. However, the provider must ensure that the submitted claim accurately reflect the services provided.
The provider must ensure that medical record documentation supports the level of service reported to a payer.

Services must meet specific medical necessity requirement in the statute, regulation and manuals and specific medical necessity criteria defined by National overage Determinations and Local Coverage Determinations (if any exist for the service reported on the claim. For every service billed, you must indicate the specific sign, symptom or patient complaint that make the service reasonable and necessary.

Must
• to talk about something that has to be done because it’s compulsory or obligatory (that is, it’s absolutely necessary to obey a rule, law, order, or instruction):

Should
• to talk about what we think is the right or correct thing to do, especially from the point of view of duty or appropriateness:

Ought
• to express the view that something is the right thing to do, because it’s morally correct, polite, or someone’s duty:
Definition of will
past would play \(\text{w} \quad \text{d}, \{ \text{, wud}\), present singular & plural will
transitive verb
: desire, wish <call it what you will>
verbal auxiliary
1 — used to express desire, choice, willingness, consent, or in negative constructions refusal <no one would take the job> <if we will all do our best> <will you please stop that racket>
2 — used to express frequent, customary, or habitual action or natural tendency or disposition <will get angry over nothing> <will work one day and loaf the next>
3 — used to express futurity <tomorrow morning I will wake up in this first-class hotel suite — Tennessee Williams> <will get angry over nothing> <will work one day and loaf the next>
4 — used to express capability or sufficiency <the back seat will hold three passengers> <will get angry over nothing> <will work one day and loaf the next>
5 — used to express probability and often equivalent to the simple verb <that will be the babysitter> <will get angry over nothing> <will work one day and loaf the next>
6 a — used to express determination, insistence, persistence, or willfulness <I have made up my mind to go and go I will>b — used to express inevitability <accidents will happen> <will get angry over nothing> <will work one day and loaf the next>
7 — used to express a command, exhortation, or injunction <you will do as I say, at once>
intransitive verb
: to have a wish or desire <whether we will or no>
The provider must ensure that medical record documentation supports the level of service reported to a payer.

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Like to have
Should have
Must have

Major concepts of Documentation

- Medical Necessity
- Coding Guidelines
- Over Documentation
- Cut and Paste / Cloning
- Signature Guidelines
- Scribes
- Signs / Symptoms
- Inferred Order
- Whole Chart
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

Medical Necessity

EXCLUSIONS FROM COVERAGE AND MEDICARE AS SECONDARY PAYER

Sec. 1862 (42 U.S.C. 1395l) (a) 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—

(1)(A) 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;

(2)(B) in the case of items and services described in section 1861(p)(4), which are not reasonable and necessary for the prevention of illness;

(3) in the case of hospice care, which are not reasonable and necessary for the palliation or management of terminal illness;

(4) in the case of clinical care items and services provided with the concurrence of the Secretary and with respect to research and experimentation conducted by, or under contract with, the Medicare Payment Advisory Commission or the Secretary, which are not reasonable and necessary to carry out the purposes of section 1800(a)(6).
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.

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.
This section is applicable for MACs, CERT, SMRC, and ZPICs. This section does not apply to Recovery Auditors.

For medical review purposes, Medicare requires that services provided/ordered be authenticated by the author. The method used shall be a handwritten or electronic signature. Stamped signatures are not acceptable.

EXCEPTION: Facsimiles of original written or hand signed signatures are acceptable for the certification of medical necessity. For exceptions, see below.

EXCEPTION 2: There are some circumstances for which an original signature is required. For example, original copies of new clinical diagnostic tests are not required to be signed. The rates in ACM 1940 and Pub 100-03, chapter 11, §110.4 state that if the order for the clinical diagnostic test is unsigned, there must be medical documentation (e.g., a progress note) by the ordering physician that he/she assessed the clinical diagnostic test be performed. This documentation should contain the fact that the test be performed must be authenticated by the author via a handwritten or electronic signature.

EXCEPTION 3: Other regulations and the CMS instructions regarding conditions of payment related to signatures (such as (a) intercessor standards for (b) medical necessity (c) therapy procedures. For medical review purposes, if the relevant regulations, NCCO, LCD, and CMS manuals address the issue of the signature being acceptable or not, the signature must be valid. In cases where the relevant regulations, NCCO, LCD, and CMS manuals have specific signature requirements, those signature requirements take precedence.

EXCEPTION 4: CMS would permit use of another stamp or signature in accordance with the Rehabilitation Act of 1973 in the case of an author with a physical disability that would prevent him/her from writing his/her signature due to dexterity or motor facility. It is allowing the rubber stamp for purposes in certifying that they have received the document.

NOTE: Conditions of participation (COP) are not conditions of payment.

If MAC and CERT reviewers find reasons for denial mandated 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 that contains a missing or illegible signature, the reviewer shall proceed by the signature assessment. Providers should add a handwritten or electronic signature to the medical record, before the short delay that occurs during the transcription process but instead should make use of the signature authentication process. The signature authentication process described below should also be used for illegible signatures.
A. Handwritten Signature

A handwritten signature is a mark or sign by an individual on a document signifying knowledge, approval, acceptance or obligation.

- If the signature is illegible, MAC’s, ZPG’s, SMBC, and CERT shall consider evidence in a signature log, attestation statement, or other documentation submitted to determine the identity of the author of a medical record entry.
- If the signature is missing from an entry, MAC’s, SMBC, and CERT shall address the issue during the review of the claim (e.g., the signature will proceed as if the entry was not received).
- If the signature is missing from any other medical documentation (other than an entry), MAC’s, SMBC, and CERT shall accept a signature attestation from the author of the medical record entry.

B. Signature Log

Provider records shall include a signature log in the documentation they submit that lists the type or printed name of the author associated with initial or illegible signatures. The signature log might be included, as the actual entry where the initial or illegible signature are used might be a separate document. Providers should encourage providers to list their credentials in the log. However, providers should not deny a claim for a signature log that is missing. Providers should consider all submitted signature logs regardless of the date they were entered. Reviewers are encouraged to fill signature logs in an easily accessible manner to minimize the cost of future reviews where the signature log may be assessed upon.

C. Signature Attestation Statement

Providers will sometimes include an attestation statement in the documentation they submit. In order to be considered valid, Medicare medical records 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, ______ (full name of the physician/practitioner), hereby attest that the medical record entry ______ (date of entry) was signed by ______ (signature of the physician/practitioner or delegate), as authorized in the above-listed Medicare beneficiary. I do hereby attest that the information is true, accurate, and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact subject me to administrative, civil, or criminal liability."

Although this format is acceptable, the OIG currently requires our network providers to use a certain form or format. A general request for signatures attestation shall be considered non-standardized follow-up questions from the contractors to the provider. However, since no form for signature attestations has been approved by the Office of Management and Budget (OMB), the contractors should not give the provider any standardized format on which to submit the attestation. Once the OIG has adopted an OMB-Approved Redaction Act number to the attestation form, it will be mandatory.

Note: The MAC’s and CERT shall not consider attestation statements where there is no associated medical record entry. Reviewers shall not consider attestation statements from someone other than the author of the medical record entry in a question (even in cases where two individuals are at the same group, one should not sign for the other in a medical record entry or attestation statements). Reviewers shall consider all documents that are outside the requirements regardless of the date the attestation was created; except in those cases where the regulations or policy indicate that a signature must be placed prior to a given event or a given date. An example, if a policy requires an advance order or a given deadline, the provider must sign the claim of care before therapy begins, an attestation can be used to clarify the density associated with an illegible signature. However, such attestations cannot be used to "facilitate" the plan of care.

D. Signature Guidelines

The guidelines below will assist in determining whether to consider the signature requirements met:

- Include situations where the guidelines indicate "signature requirements met," otherwise, you will consider the entry.
- In situations where the guidelines indicate "contact billing provider and ask for a non-standardized follow-up question," the reviewer should contact the provider or organization that billed the claim and ask if the billing entity would like to submit an attestation statement or log. In cases where the signature is missing or illegible, the reviewer should consider the contents of the medical record entry.
- In cases where a date has been requested, an attestation statement or log, the date for completing the review is estimated to 15 days. The estimate starts upon receipt of the signature attestation or log.
- The MAC’s, CERT and ZPG’s shall document all contacts with the provider and/or other efforts to authenticate the signature.

Note: The MAC’s, CERT and ZPG’s shall not contact the billing entity when the claim has been denied for reasons unrelated to the signature requirement.
### Signature Requirement Met

<table>
<thead>
<tr>
<th>Follow-up Question</th>
<th>X</th>
<th>X</th>
</tr>
</thead>
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#### Electronic Signatures

Providers using electronic systems need to recognize that there is a potential for misuse of devices with alternative signature methods. For example, providers need a current and unique signature algorithm and software that cannot be modified against unauthorized use. Providers should also adopt administrative procedures that correspond to electronic standards and laws. The individual whose name is on the alternative signature method and the provider must have the responsibility to ensure that the authenticity of the information for which an alternative has been provided. Physicians are encouraged to check with their attorneys and regulatory agencies concerning the use of alternative signature methods.

#### Electronic Prescribing

Electronic prescribing (e-prescribing) is the transmission of prescriber or prescriber-related information through electronic media. E-prescribing takes place between prescriber and dispensing pharmacy. Prescriber orders drugs using E-prescribing protocols. If a prescriber orders or augments an electronic prescription, the pharmacist must ensure that the prescriber's signature is legible and readable. E-prescribing can reduce errors, enhance patient safety, and improve medication adherence. A qualified e-prescribing system is one that meets the Medicare Part D requirements described in 42 CFR 431.180 (Standards for Electronic Prescribing).

1. **E-Prescribing for Part D Medications (Other Than Controlled Substances)**

   The MAC, CERP, and EZC protocols shall accept as valid any Part B medication, other than controlled substances, ordered through a qualified e-prescribing system. The Medicare Part D electronic prescription system, a qualified e-prescribing system, is one that meets all MAC, CERP, and EZC requirements. Where Part B medications have been ordered through a qualified e-prescribing system, the pharmacy shall not require the provider to produce handwritten prescriptions for any medications on a valid order.

2. **E-Prescribing for Part B Controlled Substance Medications**

   Historically, the Drug Enforcement Agency (DEA) has not permitted the prescribing of controlled substances through e-prescribing systems. Therefore, when prescribing controlled substances for a Part B prescription, the provider must use a written prescription for each controlled substance. However, the DEA is in the process of developing requirements for electronic prescriptions for controlled substances. Further information on controlled substances, including 42 CFR 431.180, 431.185, and 431.187, can be found on the DEA website.

3. **E-Prescribing for Medications Involving BDI**

   The MAC, CERP, and EZC reservoirs shall accept as valid any e-prescribed order for medication, except for Durable Medical Equipment (DME) other than controlled.
substance. For the purpose of conducting NDA or medical review, such reviews shall be submitted to the designated requestor.

II. Additional Signature Requirements

A. Description of Equipment, Prescription, and Supplies (Section 1121)

Refers to PMI chapter 5 for further details regarding additional signature requirements for DOD/DoD.

B. Signature Timing Requirements

For medical review purposes, if the relevant regulations, NCO, CMS, and other CMS manuals are cited on whether the signature must be dated, the NACO, CDE and DOD/DoD should ensure that the documentation contains enough information for the reviewer to determine the date on which the service was rendered or ordered.

Example: The claim submitted for services is for a hospital visit on October 4. The ADR improvement is one month from the hospital, medical visits (continued). There is no record of the provider's signature on the claim. To ensure that the signature is dated, the claim is sent to the provider's office.

The reviewer should date the signature that was entered on October 4.

I. Additional Documentation Requirements

The CDE may require that the signature be dated as follows: (1) to ensure that the signature is dated, (2) to ensure that the signature is dated to ensure that the ADR improvement is one month from the hospital, medical visits (continued). There is no record of the provider's signature on the claim. To ensure that the signature is dated, the claim is sent to the provider's office.

The reviewer should date the signature that was entered on October 4.

The following is a sample language that reviewers may choose to use in certain situations:

Note: Please be sure to check your own state regulations.

1. Additional Signature Requirements

The CDE may require that the signature be dated as follows: (1) to ensure that the signature is dated, (2) to ensure that the signature is dated to ensure that the ADR improvement is one month from the hospital, medical visits (continued). There is no record of the provider's signature on the claim. To ensure that the signature is dated, the claim is sent to the provider's office.

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Guidelines for Medical Record Documentation

To reduce the amount of documentation involved, many physicians are turning to Medical Scribe services. Medicare does not have regulations for or a definition of these services, but they are identified by the language of the Joint Commission, with which Scribes agree.

To achieve an unbroken patient flow, Scribes are required to enter information into the Electronic Medical Record (EMR) or chart at the direction of a physician or practitioner (licensed independent practitioners, Advanced Practice Registered Nurses or Physician Assistants). The Joint Commission stated that the scribe does not and may not act independently but can document the previously determined physician’s or practitioners’ decision and/or orders.

Scribes also aid the practitioners faced with noting the EMR and in locating information such as lab results and test results. They can support work flow and documentation for medical record auditing, as the Joint Commission’s “Use of Enhanced Review” is Section IV. The physician delivers the service and creates the record; the Scribe assists with documentation within the medical record.

Physicians using Medical Scribe services must:

- Follow documentation guidelines established in United Caring Policy: appropriate selection of level 2 (E&M) Service on CPT/HCPCS Only Manual (OCH), Publication 2014, Medicare Claims Processing Manual, Chapter 12, Section 41.2 (b) (1) (ii)
- Documentation must support medical necessity of level of service billed and level of service components required, follow HCPCS and Evaluation and Management (EM) Documentation Guidelines.
- Scribe can verify accuracy and reliability of the documentation.
- Documentation must identify who recorded service.
- Record entry does not name the person “voting on a writer for Dr. X.”
- Example: “J. ___________ is working in the office with Dr. __________.”
- Nurse must sign the abbreviation and date signature.
- Documentation must identify, who performed service.
- Physician or practitioner must sign the document and confirm that the physician ordered the test. (This is not a reflexive order). A test to be ordered by the ordering physician and performed by the Scribe is an example of optimal performance of the test. The test is then signed by a practitioner.
- Physician or practitioner must sign the interpretation and date signature.
- Culinary, nutrition, lab, IT, and administrative skills must be utilized by the Scribe. The Scribe must use the 50% of the time to test the patient’s needs.
- Documentation must be accurate and complete.
- Scribe must use the Electronic Medical Record (EMR) and the notes of the patient.
- Physicians must be used in the Scribe.
- All electronic documentation must be completed during the visit. The EMR and the Visit Notes are not considered during the care. This may include the physician’s review and confirmation of the EMR and the Visit Notes and the physician’s ordering of the non-surgical or surgical service. Scribes must document the completed procedure with the physician’s signature in the EMR.

Last Updated Oct 4, 2015
Scribe


- Noridian is a MAC for California, Nevada

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Signs and Symptoms

**NUMBER OF DIAGNOSES OR MANAGEMENT OPTIONS**

The number of possible diagnoses and/or the number of management options that must be considered is based on the number and types of problems addressed during the encounter, the complexity of establishing a diagnosis and the management decisions that are made by the physician.

Generally, decision making with respect to a diagnosed problem is easier than that for an identified but undiagnosed problem. The number and type of diagnostic tests employed may be an indicator of the number of possible diagnoses. Problems which are improving or resolving are less complex than those which are worsening or failing to change as expected. The need to seek advice from others is another indicator of complexity of diagnostic or management problems.

DG: For each encounter, an assessment, clinical impression, or diagnosis should be documented. It may be explicitly stated or implied in documented decisions regarding management plans and/or further evaluation.

- For a presenting problem with an established diagnosis the record should reflect whether the problem is: a) improved, well controlled, resolving or resolved; or, b) inadequately controlled, worsening, or failing to change as expected.
- For a presenting problem without an established diagnosis, the assessment or clinical impression may be stated in the form of a differential diagnoses or as "possible", "probable", or "rule out" (R/O) diagnoses.
Inferred Order

• If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.

• 1995 Documentation Guidelines For Evaluation and Management Services

Whole Chart

KCD-10-CM Official Guidelines for Coding and Reporting FY 2016

Narrative changes appear in bold text. Items underlined have been moved within the guidelines since the FY 2014 version. Italics are used to indicate revisions to heading changes or text. White space above and below guidelines and revised items have been removed. The entire record should be reviewed to determine the specific reason for the encounter and the conditions treated.

The Centers for Medicare and Medicaid Services (CMS) and the National Center for Health Statistics (NCHS), two departments within the U.S. Federal Government’s Department of Health and Human Services (HHS) provide the following guidelines for coding and reporting using the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM). These guidelines should be used as a companion document to the official version of the ICD-10-CM as published on the NCHS website. The ICD-10-CM is a morbidity classification published by the United States for classifying diagnoses and reasons for visits in all health care settings. The ICD-10-CM is based on the ICD-10, the statistical classification of disease published by the World Health Organization (WHO).

These guidelines have been approved by the four organizations that make up the Coordinating Parties for the ICD-10-CM: the American Hospital Association (AHA), the American Health Information Management Association (AHIMA), CMS, and NCHS.

These guidelines are a set of rules that have been developed to accompany and complement the official conventions and instructions provided within the ICD-10-CM itself. The instructions and conventions of the classification take precedence over guidelines. These guidelines are to be used in conjunction with the ICD-10-CM, but provide additional instruction. Adherence to these guidelines when assigning ICD-10-CM diagnosis codes is required under the Health Insurance Portability and Accountability Act (HIPAA). The diagnosis codes (Tabular list and Alphabetic index) have been adopted under HIPAA for all healthcare settings. A joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures. These guidelines have been developed to assist both the healthcare provider and the coder in identifying those diagnoses that are to be reported. The importance of consistent, complete documentation in the medical record cannot be overstated. The entire record should be reviewed to determine the specific reason for the encounter and the conditions treated.

Questions

- Do you have any questions?

- Support is also available via PMI’s complimentary online Discussion Forum. Post your questions at http://www.pmiMD.com/pmiForum/rules.asp

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