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CPA, CMC, CMIS, CMOM

On the topic:
Leveling E/M Services in EHR
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LEVELING E/M SERVICES IN EHR

Presented by
Maxine Collins
MBA, CPA, CMC, CMIS, CMOM
Practice Management Institute®
and CoreMD Partners LLC

AGENDA

1. Introduction - the Importance of Medical Record Documentation
2. The Electronic Medical Record – Selecting the Level
3. CMS EHR Guidance
4. Recent CMS updates in Recovery Audit Program
5. OIG alerts
6. Evaluation and Management Coding Guidelines and the EHR
7. “Cloning” in the EHR
8. “Best Practices
9. The Future
10. Questions?
MEDICAL RECORD DOCUMENTATION

Learn about the general principles of evaluation and management (E/M) documentation, common sets of codes used to bill for E/M services, and E/M services providers.

GENERAL PRINCIPLES OF E/M DOCUMENTATION

If it is not documented, it has not been done.

1995 DOCUMENTATION GUIDELINES FOR EVALUATION AND MANAGEMENT SERVICES

I. INTRODUCTION

WHAT IS DOCUMENTATION AND WHY IS IT IMPORTANT?

Medical record documentation is required to record pertinent facts, findings, and observations about an individual's health history including past and present illnesses, examinations, tests, treatments, and outcomes. The medical record chronologically documents the care of the patient and is an important element contributing to high-quality care. The medical record facilitates:

- the ability of the physician and other healthcare professionals to evaluate and plan the patient's immediate treatment, and to monitor his/her healthcare over time;
- communication and continuity of care among physicians and other healthcare professionals involved in the patient’s care;
- accurate and timely claims review and payment;
- appropriate utilization review and quality of care evaluations; and
- collection of data that may be useful for research and education.

An appropriately documented medical record can reduce many of the "hassles" associated with claims processing and may serve as a legal document to verify the care provided, if necessary.

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TAKE IT PERSONALLY

• We have all reviewed the items on the previous slide before – but why is it important to you that your medical record be accurate?
• Why is it important to you that your child’s medical record is accurate?
• Think of some outcomes of incorrect medical records in this era of electronic exchange of protected healthcare information.
• The underlying Principles of Medical Record documentation have not changed.

REVIEW OF DOCUMENTATION GUIDELINES AND THE CMS AUDIT WORKSHEET
II. GENERAL PRINCIPLES OF MEDICAL RECORD DOCUMENTATION

The principles of documentation listed below are applicable to all types of medical and surgical services in all settings. For Evaluation and Management (E/M) services, the nature and amount of physician work and documentation varies by type of service, place of service and the patient's status. The general principles listed below may be modified to account for these variable circumstances in providing E/M services.

1. The medical record should be complete and legible.
2. The documentation of each patient encounter should include:
   - reason for the encounter and relevant history, physical examination findings, and prior diagnostic test results;
   - assessment, clinical impression, or diagnosis;
   - plan for care; and
   - date and legible identity of the observer.
3. If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.
4. Past and present diagnoses should be accessible to the treating and/or consulting physician.
5. Appropriate health risk factors should be identified.
6. The patient’s progress, response to and changes in treatment, and revision of diagnosis should be documented.
7. The CPT and ICD-9-CM codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.

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II. DOCUMENTATION OF E/M SERVICES

This publication provides definitions and documentation guidelines for the three key components of E/M services and for visits which consist predominantly of counseling or coordination of care. The three key components—history, examination, and medical decision making—appear in the descriptors for office and other outpatient services, hospital observation services, hospital inpatient services, consultations, emergency department services, nursing facility services, domiciliary care services, and home services. While some of the text of CPT has been repealed in this publication, the reader should refer to the CPT for the complete descriptors, E/M services and instructions for selecting a level of service. Documentation guidelines are identified by the symbol • DG.

The descriptors for the levels of E/M services recognize seven components which are used in defining the levels of E/M services. These components are:

- history;
- examination;
- medical decision making;
- counseling;
- coordination of care;
- nature of presenting problem; and
- time.

The first three of these components (i.e., history, examination and medical decision making) are the key components in selecting the level of E/M services. An exception to this rule is the case of visits which consist predominantly of counseling or coordination of care. for these services time is the key or controlling factor to qualify for a particular level of E/M service.

For certain groups of patients, the recorded information may vary slightly from that described here. Specifically, the medical records of infants, children, adolescents and pregnant women may have additional or modified information recorded in each history and examination area.

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DOCUMENTATION REQUIREMENTS OF THE HISTORY COMPONENT

- DG: The CC, ROS and PFSH may be listed as separate elements of history, or they may be included in the description of the history of the present illness.

- DG: A ROS and/or a 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/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.

- DG: If the physician is unable to obtain a history from the patient or other source, the record should describe the patient's condition or other circumstance which precludes obtaining a history.

Definitions and specific documentation guidelines for each of the elements of history are listed below.

CHIEF COMPLAINT (CC)

The CC is a concise statement describing the symptom, problem, condition, diagnosis, physician recommended return, or other factor that is the reason for the encounter.

- DG: The medical record should clearly reflect the chief complaint.

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E/M Documentation Auditor’s Instructions

Refer to data section (table below) in order to quantify. After referring to data, circle the entry farthest to the RIGHT in the table, which best describes the NPI, ROS and PFSH. If one column contains three circles, draw a line down that column to the bottom row to identify the type of history. If no column contains three circles, the column containing a circle farthest to the LEFT identifies the type of history.

After completing this table which classifies the history, circle the type of History within the appropriate grid in Section 5.

**Complete ROS:** 10 or more systems or the pertinent positives and/or negatives of some systems with a statement “all others negative”.

**Complete PFSH:** 2 history areas: a) Established Patients - Office (Outpatient) Care; b) Emergency Department.

**5 history areas:** a) New Patients - Office (Outpatient) Care, Domiciliary Care, Home Care; b) Initial Hospital Care; c) Initial Nursing Facility Care.

NOTE: For certain categories of E/M services that include only an internal history, it is not necessary to record information about the PFSH. Please refer to procedure code descriptions.
## NOVITAS and THE EXAM GUIDELINES

- Clinical reviewers use one of the guidelines provided by CMS and the AMA to make determination whether an exam is expanded problem, focused, or detailed; whichever is most beneficial to the physician
  - 1995 E/M Guidelines
  - 1997 E/M Guidelines
- Under the 1995 guidelines, both the Expanded Problem focused examination and the detailed examination provide for:
  - Up to 7 systems or 7 body areas.
  - Has led to variability in reviews using the 1995 Guidelines, and requiring an interpretation for proper and consistent implementation of E/M guidelines.
  - As a result of the confusion, Novitas "nurse reviewers and physicians have clinically derived a method called "4 x 4", to assist in implementing E/M guidelines and decreasing one area of ambiguity".

---

### 2. Examination

Refer to data section (table below) in order to quantify. After referring to data, identify the type of examination. Circle the type of examination within the appropriate grid in Section 5.

<table>
<thead>
<tr>
<th>Limited to affected body area or organ system (one body area or system related to problem)</th>
<th>PROBLEM FOCUSED EXAM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affected body area or organ system and other symptomatic or related organ system(s) (additional systems up to total of 7)</td>
<td>EXPANDED PROBLEM FOCUSED EXAM</td>
</tr>
<tr>
<td>Extended exam of affected area(s) and other symptomatic or related organ system(s) (additional systems up to total of 7 or more depth than above)</td>
<td>DETAILED EXAM</td>
</tr>
<tr>
<td>General multi-system exam (8 or more systems) or complete exam of a single organ system (complete single exam not defined in these instructions)</td>
<td>COMPREHENSIVE EXAM</td>
</tr>
</tbody>
</table>

### Exam Table

<table>
<thead>
<tr>
<th>Body areas:</th>
<th>1 body area or system</th>
<th>Up to 7 systems</th>
<th>Up to 7 systems</th>
<th>8 or more systems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head, including face</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chest, including breasts and axilla</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abdomen</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neck</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Back, including spine</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genitals, groin, buttocks</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Each extremity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**EXAM**

<table>
<thead>
<tr>
<th>Organ systems:</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Constitutional</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extrem.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Endocr.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resp</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Musclo</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psych</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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NOVITAS – THE “4 X 4” METHOD (FOR THE 1995 EXAM)

• The 4 x 4 method is:
  – A way to ensure you have **4 elements in 4 body areas or organ systems** to reduce reviewer variability in audits.
  – Is consistent with the way medicine is practiced as confirmed in the Documentation Coding & Billing by Laxmaiah Manchikanti, M.D. and A Guide to Physical Examination by Barbara Bates, M.D.
  – Nurse reviewers also use their clinical knowledge when reviewing the medical record documentation to determine correct and appropriate level of care.
  – “Note: Clinical inference overrides the 4 x 4 method; and is in keeping with the CMS Instructions for reviewing all medical records.”

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3. Medical Decision Making

Number of Diagnoses or Treatment Options

Identify each problem or treatment option mentioned in the record. Enter the number in each of the categories in Column B in the table below. (There are maximum number in two categories.)

<table>
<thead>
<tr>
<th>Problem(s) Status</th>
<th>Number</th>
<th>Points</th>
<th>Recall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe or minor (stable, improved or winnings)</td>
<td>M = 2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Est. problem (to- examiner); unstable, improved</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Est. problem (to- examiner); necrotizing</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>New problem (to-examiner); no additional workup planned</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>New prob. (to-examiner) odd; workup planned</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>4</strong></td>
<td><strong>4</strong></td>
<td><strong>4</strong></td>
</tr>
</tbody>
</table>

Multiply the number in columns B & C and put the product in column D. Enter a total for column D.

<table>
<thead>
<tr>
<th>Number of Diagnoses or Treatment Options</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>4</strong></td>
<td><strong>4</strong></td>
<td><strong>4</strong></td>
<td><strong>4</strong></td>
</tr>
</tbody>
</table>

Amount and/or Complexity of Data Reviewed

For each category of reviewed data identified, circle the number in the points column. Total the points.

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

Bring total to line A in Final Result for Complexity (table below)

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### 5. LEVEL OF SERVICE

#### New Office, Outpatient and Emergency Room

<table>
<thead>
<tr>
<th>History</th>
<th>New Office / Outpatient / ER</th>
<th>Established Office / Outpatient</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Requires 3 components within shaded area</td>
<td>Requires 2 components within shaded area</td>
</tr>
<tr>
<td>PF</td>
<td>PF</td>
<td>PF</td>
</tr>
<tr>
<td>ER: PF</td>
<td>ER: EF</td>
<td>ER: EF</td>
</tr>
<tr>
<td>D</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>ER: B</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>ER: C</td>
<td>C</td>
<td>C</td>
</tr>
</tbody>
</table>

#### Examination

<table>
<thead>
<tr>
<th>Examination</th>
<th>ER: PF</th>
<th>ER: EF</th>
<th>D</th>
<th>C</th>
<th>ER: D</th>
<th>ER: C</th>
<th>ER: PF</th>
<th>ER: EF</th>
<th>D</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td>PF</td>
<td>PF</td>
<td>EPF</td>
<td>D</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>PF</td>
<td>EPF</td>
<td>D</td>
<td>C</td>
</tr>
<tr>
<td>Complex Level</td>
<td>SF</td>
<td>SF</td>
<td>L</td>
<td>M</td>
<td>H</td>
<td>H</td>
<td>SF</td>
<td>SF</td>
<td>L</td>
<td>M</td>
</tr>
<tr>
<td>Average Time (minutes)</td>
<td>10</td>
<td>20</td>
<td>50</td>
<td>40</td>
<td>50</td>
<td>50</td>
<td>50</td>
<td>50</td>
<td>10</td>
<td>15</td>
</tr>
</tbody>
</table>

#### Level

<table>
<thead>
<tr>
<th>Level</th>
<th>New Office (ER)</th>
<th>Established Office (ER)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>I</td>
<td>I</td>
</tr>
<tr>
<td>II</td>
<td>II</td>
<td>II</td>
</tr>
<tr>
<td>III</td>
<td>III</td>
<td>III</td>
</tr>
<tr>
<td>IV</td>
<td>IV</td>
<td>IV</td>
</tr>
<tr>
<td>V</td>
<td>V</td>
<td>V</td>
</tr>
</tbody>
</table>

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THE ELECTRONIC MEDICAL RECORD AND
AUTOMATED CODE ASSIGNMENT

Do the Rules Differ for the Electronic Medical Record vs. the Paper Record?
Answer: No. We have had more recent items added referring to electronic records, but for the most part the rules have not changed as technology has continued to advance.

Why the push for conversion from paper to electronic?
Answer: The government has set specific goals to achieve the interoperability of the electronic medical records – first within the U.S., then eventually worldwide.

What is the Incentive for Physicians/Providers to move to EHR?
Answer: Meaningful Use and the penalties associated with not converting to electronic records.

Most who have converted to an EHR soon realize that there are advantages and benefits to be gained if the system is an efficient and user friendly, and, IF the staff receives adequate training.

WHAT ARE SOME OF THE ADVANTAGES AND DISADVANTAGES OF AUTOMATED CODE ASSIGNMENT BY EHR SYSTEMS?

• According to a study performed by the Foundation of Research and Education, American Health Information Management Association (AHIMA) www.ahima.org, the following advantages to automated coding in the medical record were stated (shown on the next slide, and taken directly from the study: “Automated Coding Software: Development and Use to Enhance Anti-Fraud Activities”, July 11, 2005)

• Compare your experiences with EHR with the findings of the study. Do you agree?
ADVANTAGES
- Increase in coding productivity
- Increase in coding consistency
- Availability of a coding audit trail
- Data query ability
- Potential for more comprehensive code assignment
- Potential increase in coding accuracy
- Potential decrease in coding costs
- Improved documentation
- Decreased documentation costs
- Creation of ancillary documentation
- Use of free text for recording documentation
- System improvements through feedback

DISADVANTAGES
- User-specific integration
- User acceptance and change management
- High cost (initial purchase and ongoing maintenance)
- Potential for coding errors or fraudulent claims
- Use of structured input
- Extensive software development efforts
- Potential automated coding mistakes
- Reliance on electronic documents
- Complexity, quality, and format of health record documentation
- Technological limitations
- Lack of industry standards

HOW CAN YOU HELP ALLEVIATE SOME OF THE DISADVANTAGES?
- **Educate/train all staff and physicians/providers**. Regardless of what code is chosen by the EHR, the physician/provider is ultimately responsible for the code submitted on the federal claim form.
- **Hold your software vendor responsible** for living up to the promises made by the sales representatives.
  - Make sure that they show you how the coding tools in their software comply with the published E/M Documentation Guidelines.
  - Have them explain how the specific tools capture the E/M information from each portion of the physician’s notes (i.e. HPI, Past Medical History, Family History, Social History, ROS, Exam, Assessment and Plan).
  - Get explanation from your vendor as to how the overall scores are determined from the information and when and how time can be used to determine the E/M code.
• **Keep up to date with all coding guidelines and changes.** This is imperative and will provide the knowledge to be able to prevent complete reliance on the level of E/M service suggested by the software.
  – Audits and reviews are occurring more frequently by more agencies and organizations. Data mining is being used to detect patterns of coding by providers.
  – The Electronic Health Record and the associated assigned codes are under scrutiny.

• **Be aware of the use of wording in the medical record that comes from default templating, macros or simply checking boxes.** (i.e., patient presents coughing and wheezing, yet ROS for respiratory is checked as normal)

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**EHR GUIDANCE – MEDICARE INTEGRITY MANUAL**

• **3.3.2.1.1 Progress Notes and Templates**
  – (Rev. 455, Issued: 03-15-13, Effective: 12/10/12, Implementation: 03-21-13)
  – **A. Definitions** – For the purposes of Section 3.3.2.1.1, the following definitions apply:
    1. “**Progress Notes**” – visit notes, encounter notes. Evaluation and Management documentation, office notes, face-to-face evaluation notes or any other type of record of the services provided by a physician or other licensed certified medical professional (LCMP) in the medical record. Progress notes may be in a form or format, hardcopy or electronic.
    2. “**Template**” – a tool/instrument/interface that assists in documenting a progress note. Templates may be paper or electronic.
    3. Electronic records may involve any type of interface including but not limited to:
       1. Simple electronic documents
       2. Sophisticated graphical user interfaces (GUIs) with clinical decision and documentation support prompts, or
       3. Electronic pen capture devices
    4. “**Licensed/Certified Medical Professional (LCMP)**” – Medical professional licensed or certified to practice in the state in which services are rendered. For the purposes of documenting DMEPOS items, the physician or LCMP must not have a financial relationship with the DMEPOS supplier.
CMS WARNING CONCERNING TEMPLATES AND “CLONING” – SIGNIFICANT DEVELOPMENT

• “CMS does not prohibit the use of templates to facilitate record-keeping. CMS also does not endorse any particular template.”

• “Some templates provide limited options/space for the collection of information, such as by using “check boxes”, predefined answers, limited space to enter information, etc. CMS discourages the use of such templates. Claim review experience shows that limited space templates often fail to capture detailed clinical information to demonstrate that all clinical and coding guidelines are met.”

• “Physicians/LCMPs should be aware that templates designed to gather selected information focused primarily for reimbursement services are often insufficient to demonstrate that all coding and coverage requirements are met. This is often because these documents generally do not provide sufficient information to adequately show that the medical necessity criteria of the item/service are met.”

• “If a Physician/LCMP chooses to use a template during a patient visit, CMS encourages selecting one that allows for full and complete collection of information to demonstrate that all coverage and coding criteria are met.”

Source: Medicare Program Integrity Manual; Chapter 3 - Verifying Potential Errors and Taking Corrective Action; 3.3.2.1.1: Progress Notes and Templates, Revised 455, 03/15/13

CMS MANUAL SYSTEM – Pub. 100-04 Medicare Claims Processing

• Transmittal 178, Date: May 14, 2004 – Change Request 2321:
  – 30.6 – Evaluation and Management Service Codes – General (Codes 99201-99499); Rev. 178, 05-14-04;
  – A. Use of CPT Codes
    • “Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code.
    • It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed.”
    • “Documentation should support the level of service reported. The service should be documented during, or as soon as practicable after it is provided in order to maintain an accurate medical record.”
CMS MANUAL SYSTEM - Pub. 100-04

– B. Selection of Level of Evaluation and Management Service
  • “Instruct physicians to select the code for the services based upon the content of the service.”
  • “The duration of the visit is an ancillary factor and does not control the level of the service to be billed unless more than 50 percent of the face-to-face time (for non-inpatient services) or more than 50 percent of the floor time (for inpatient services) is spent providing counseling or coordination of care.....”

– D. Use of Highest Levels of Evaluation and Management Codes
  • “Carriers must advise physicians that to bill the highest levels of visit and consultation codes, the services furnished must meet the definition of the code (i.e., to bill a Level 5 new patient visit, the history must meet the CPT’s definition of a comprehensive history).”
  • “The comprehensive history must include a review of all systems and a complete past (medical and surgical) family and social history obtained at that visit.
  • In the case of an established patient, it is acceptable for a physician to review the existing record and update it to reflect only changes in the patient’s medical, family, and social history from the last encounter, but the physician must review the entire history for it to be considered a comprehensive history.” However, we must refer to the date and location of the previous visit in order to get credit.
  • “The comprehensive examination may be a complete single exam such as cardiac, respiratory, psychiatric, or a complete multi-system examination.”
**ELECTRONIC HEALTH RECORDS (EHR)**

- According to CMS:
  - Medical record keeping within an EHR deserves special considerations; however the principles specified remain fundamental and necessary for document submission to MACs, CERT, Recovery Auditors, and ZPICs.
  - Records sourced from electronic systems containing amendments, corrections or delayed entries must:
    A. Distinctly identify any amendment, correction or delayed entry;
    B. Provide a reliable means to clearly identify the original content, the modified content and the date and authorship of each modification of the record.

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**CMS.GOV – RECENT UPDATES IN RECOVERY AUDIT PROGRAM (RACs) – WATCH THESE GUYS!**

- **New Sheriff’s in Town?**
  - December 7, 2016 – CMS posted the Fiscal Year 2015 Recovery Audit Program to Congress. You can view in downloads section of Recovery Audit Program’s main page.
  - October 31, 2016 – CMS has awarded the next round of Medicare Fee-for-Service Recovery Audit Contractor (RAC) contracts to:
    - Region 1 – Performant Recovery, Inc.
    - **Region 2 – Cotiviti, LLC (Texas included in this Region)**
    - Region 3 - Cotiviti, LLC
    - Region 4 - HMS Federal Solutions
    - Region 5 - Performant Recovery, Inc. (DMEPOS, Home Health/Hospice)
OIG ALERTS

• Recommendations in 2013 from OIG to CMS to “beef up” scrutiny of fraud vulnerabilities in electronic health records:
  – Report stated, “HHS must do more to ensure that all hospitals’ EHRs contain safeguards and that hospitals use them to protect against electronically enabled healthcare fraud.”
  – Audit logs should be in operation where an EHR is available.
  – CMS encouraged to develop concrete guidelines around the use of copy-and-paste functions in an EHR.
  – According to the data from OIG’s report, audit functions are not being utilized and only around 25% of hospitals had policies in place regarding copy-and-paste functions.
  – The recommendations are now being repeated in more recent OIG reports.
  – The writing is on the wall for upcoming audits for all providers in this regard!
OFFICE OF INSPECTOR GENERAL (OIG)

• “CMS AND ITS CONTRACTORS HAVE ADOPTED FEW PROGRAM INTEGRITY PRACTICES TO ADDRESS VULNERABILITIES IN EHRS”- Daniel R Levinson, Inspector General, January, 2014, OEI-01-11-00571:
  – Executive Summary – Why We Did This Study:
    • “Experts in health information technology caution that EHR technology can make it easier to commit fraud.”
    • “For example, certain EHR technology features may be used to mask true authorship of the medical record and distort information to inflate health care claims.”
    • “The transition from paper records to EHRs may present new vulnerabilities and require the Centers for Medicare & Medicaid Services (CMS) and its contractors to adjust their techniques for identifying improper payments and investigating fraud.”

PROGRAM INTEGRITY CONTRACTORS

• MACs – Medicare Administrative Contractors
  – Responsible primarily for processing and paying Medicare claims.
  – Collaborate with CMS and other contractors to ensure that they pay claims correctly.
  – Also educate providers on appropriate billing methods and responsible for detecting and deterring fraud.

• ZPICs – Zone Program Integrity Contractors
  – Responsible primarily for detecting and deterring Medicare fraud.
  – Investigate providers that have filed potentially fraudulent claims by a variety of methods, including prepayment and postpayment reviews and audits.
  – Also recommend that CMS or MACs revoke billing privileges

• RACs – Recovery Audit Contractors
  – Responsible primarily for identifying and reducing Medicare improper payments by detecting and recouping improper payments made on claims.

• MACs, ZPICs, and RACs rely on medical records in aspects of their program integrity work. The transition from paper records to EHRs, OIG believes, requires these contractors to adjust their techniques for identifying improper payments and investigating fraud.
OIG IN OUR LOCAL AREA! YIKES!

- **OIG Investigations in Dallas, Texas**
  - The Health Care Fraud Prevention and Enforcement Action Team (HEAT) is a systemized federal task force comprised of prosecutors from the Department of Health and Human Services (HHS), the Federal Bureau of Investigation (FBI), the Department of Justice (DOJ), the Office of Inspector General (OIG), and other government agencies. They orchestrate these investigations and prosecutions.
  - Dallas is a main focus for government prosecution:
    - individuals and health care organizations in Dallas should be aware of the increase and frequency of prosecutions carried out in the area;
    - It is one of nine areas in the United States with a HEAT task force in place.
    - Because Dallas has a large number of Medicare and other federal government health care program recipients, the government believes that there is more risk for health care fraud to occur in the area.

WHAT OIG FOUND IN THE STUDY – CMS IN TROUBLE?

- **“CMS and contractors had adopted few program integrity practices specific to EHRs.”**
  - Most contractors were reviewing EHR records the same as paper.
  - Also, not all contractors reported being able to determine whether a provider had copied language or overdocumented.
  - In addition, CMS had not followed recommendations to provide guidance to Medicare contractors on EHR fraud vulnerabilities.

- **OIG Recommendations:**
  1. CMS should provide guidance to its contractors on detecting fraud associated with EHRs and work with them on detecting fraud associated with EHRs.
  2. CMS should direct contractors to use providers’ audit logs. Audit log data distinguish EHRs from paper medical records and could be valuable to CMS’s contractors when reviewing medical records.
EXAMPLES OF MEDICARE FRAUD (from CMS)

- From the Medicare Program Integrity Manual, Chapter 4 – 4.2.1. – Examples of Medicare Fraud (Rev. 675, Issued: 09-09-16, Effective 12-12-16, Implementation: 12-12-16):
  - “The most frequent kind of fraud arises from a false statement or misrepresentation made, or caused to be made, that is material to entitlement or payment under the Medicare program.”
  - “The violator may be:
    • A Provider/supplier;
    • A Beneficiary;
    • An Employee of a provider/supplier;
    • Or some other person or business entity, including a billing service or a contractor employee.”
  - “Providers/suppliers have an obligation, under law, to conform to the requirements of the Medicare program.
  - “Fraud committed against the program may be prosecuted under various provisions of the United States Code and could result in the imposition of restitution, fines, and, in some instances, imprisonment. In addition, a range of administrative sanctions (such as exclusion from participation in the program) and civil monetary penalties may be imposed when facts and circumstances warrant such action.”

FRAUD MAY TAKE SUCH FORMS (THIS IS NOT AN EXHAUSTIVE LIST)

- Incorrect reporting of diagnoses or procedures to maximize payments;
- Billing for services not furnished and/or supplies not provided. This includes billing Medicare for appointments that the patient failed to keep;
- Billing that appears to be a deliberate application for duplicate payment for the same services or supplies, billing both Medicare and the beneficiary for the same service, or billing both Medicare and another insurer in an attempt to get paid twice;
- Altering claim forms, electronic claim records, medical documentation, etc., to obtain a higher payment amount;
- Soliciting, offering, or receiving a kickback, bribe, or rebate (e.g. paying for a referral of patients in exchange for ordering of diagnostic tests and other services or medical equipment;
- Unbundling or “exploding” charges;
- Completing Certificates of Medical Necessity for patients not personally and professionally known by the provider;
- Participating in schemes that involve collusion between a provider and a beneficiary, or between a supplier and a provider;
- Billing non-covered or non-chargeable services as covered items’
- Billing for items that are not “medically necessary”.

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STRATEGIES FOR E/M LEVELING AND DOCUMENTATION

• Accurate documentation, coding, and knowledge of the guidelines = higher reimbursement, more efficiency (therefore, less cost), and lowers the stress of fear of being audited.

• Implementing the “Seven Step Compliance Program” in your clinic/practice.
  – “Although this advice may seem self-evident, coding experts and practice management consultants say that a surprising number of doctors, especially primary care physicians (PCPs), are either unable or unwilling to follow it. Instead, they say, many routinely “downcode” when reporting their evaluation and management (E/M) services – that is, code at a lower level than the level of service they actually provide – with the result being that they are not reimbursed commensurate with the complexity of the care provided for a patient’s disease or condition.” (Source: “Cracking the code” by Jeffrey Bendix, MA, May 25, 2013; Medical Economics Practice Management Auditing.)

The above article also mentions a review of around 60,000 audits of physician billing records conducted by the AAPC in 2012 which found that 37% of the records reviewed were “undercoded or underdocumented, equating to an average of $64,000 in foregone or at-risk revenue per physician.”

BEST ANTI-FRAUD PRACTICES?

• Computer-assisted coding software that utilizes a combination of statistics-based and rules-based automated coding and a standardized national database (as opposed to a facility-specific database) (Source: Automated Coding Software: Development and Use to Enhance Anti-Fraud Activities)
  – Processes should include prepayment fraud detection using data profiling, advanced analytic models and rank scoring.
  – An advanced, certified medical coder analyst should edit and check all processes for accurate code assignment.
  – Compliance Officer should stay up to date on all insurer’s policies and Medicare’s LCDs and NCDs.
  – All staff, including MAs, CNAs, and nursing staff must be furnished information concerning any changes and be trained on each item. Communication is key.
  – Must have IT staff for maintenance of current technology.
  – Must have sufficient and in-depth physician and staff training.
  – Effective Audit Trails are imperative – must be able to identify the author of all information in the electronic medical record.
  – Reports must be pulled and reviewed for consistency in documentation and coding.
  – Knowing your coding profile can be important.
THE FUTURE?

- Data mining: being conducted by all insurance payors
- E-Discovery: Healthcare organizations must analyze how they manage information stored electronically and develop a structure and process to understand, manage and prepare for any possible litigation.
- Texas is #2 on the national list for the most improper coding and documentation!
- Watch for the RACs
- New auditing for the fee-for-value programs
- In 2016, the DOJ reported recoveries of more than 44.7 billion in civil fraud and false claims cases!!!
- Educate, Educate – Train, Train!
Tips, Tools & Techniques

- Have you ever read the Medicare Integrity Manual?
- Hold your software vendor accountable.
  - Did you actually receive the training that you needed on your software?
  - Do you know how the system actually works and where it pulls the information to determine a code?
  - Do you run reports at least monthly and analyze billing patterns?
- Review and train often on the Evaluation and Management Documentation Guidelines and monitor EHR coding patterns for accuracy.
- Keep up-to-date on your MAC’s Medical Review Items, RAC and CERT Reports – what is trending for review?
- Have an external Audit and Implement and/or Update a written Compliance Plan
- Sample audit claims before submission.

QUESTIONS

- Thank you!

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