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Meet the Presenter…

Regina Mixon Bates,
IRO, CPC, CPC-I, CMC,
CMOM, CMIS, TPA

On the topic:
Documentation and Compliance Protocol for E/M
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Documentation & Compliance
Protocols for E/M Services

Presented by:
Regina Mixon Bates, CEO
IRO, TPA, CPC, CPC-I, CMC, CMIS, CMOM

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Making your Records Documentation Count

• Medical records more than ever are being looked at to see if they meet medical necessity
• As an IRO for the last 10 years
  – I help you understand what is being looked at
  – Work with providers under CIA/IA, when there has been an audit/investigation and there was more than a 5% error rate.

Improving your Clinical Documentation

• Compliance in documentation is standard across all specialties and all E/M types.
• Evaluation and Management (E/M) error rates have historically been high. Does your office have a clinical documentation improvement plan in place?
• While copying and pasting data is not always a negative, the data copied must be reviewed for accuracy.
  – At its core, copy and paste is a benign feature. Physicians who abuse this feature, or lack foresight on its pitfalls, will eventually pay for this during an audit.
Improving your Clinical Documentation

• You must have protocols in place that stipulate a provider must review any imported data, make necessary corrections, and add their signature attesting that they reviewed the imported data and found it to be correct or made necessary modifications.
• Your policy should also stipulate the chief complaint must be compared to the treatment plan and all issues must be addressed.

Today’s Discussion Points

• Important highlights that should be mentioned on the medical record documentation for E/M services.
• Understand why the chief complaint is important and why it should show correlation between HPI/exam findings
• Learn what is documented for medical decision making to show medical necessity appropriately
• Know the key elements needed in your medical decision making
• Expert documentation tips to ensure correct coding and prevent E/M documentation errors
Statement regarding Record Cloning....

• According to the *1997 Documentation Guidelines for Evaluation and Management Services*, "Medical record documentation is required to record pertinent facts, findings, and observations about an individual's health history... (Emphasis added)" Medical record cloning will not satisfy that E/M requirement.

• Physicians’ documentation must support the medical necessity and appropriateness of the services they provide. Electronic medical record templates can assist them in this process, if care is taken to edit records to accurately reflect the condition of a patient at every patient/physician encounter. In the absence of such editing, cloning of records will most likely lead to denial of services due to lack of medical necessity and may lead to investigation of potentially fraudulent practices.
Who is looking at your records?

• Who is looking at your records?
  – RAC’s
  – ZPIC’s
  – MIC’s
  – MAC’s
  – Commercial Payors

RACs
Recovery Audit Contractors

• Purpose
  – Detect Medicare improper payments (overpayments and underpayments)
  – Correct Medicare improper payments
    • Repay underpayments
    • Collect overpayments
RACs
Recovery Audit Contractors

- **Scope:** Medicare Fee for Service payments
  - Incorrect payment amounts
  - Claims for non-covered services
  - Incorrectly coded claims
  - Duplicate claims/services

RACs Compensation

- CMS pays RACs on the basis of a contingency fee
  - Initially, the fee was based only upon the amount of overpayments identified
  - RACs will earn contingency fees ranging from 9% to 12.5% of the payments they collect from health care providers.
  - Underpayments were added as a basis of payment in 2006
### RACs Recovery Audit Contractors

<table>
<thead>
<tr>
<th>Region</th>
<th>States</th>
<th>Websites</th>
<th>Email</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Region 1</td>
<td>CT, IN, KY, MA, MI, RI, NH, NY, OH, WI, and VT</td>
<td><a href="https://performanceac.com/">https://performanceac.com/</a></td>
<td><a href="mailto:info@performanceac.com">email: info@performanceac.com</a></td>
<td>1.888.291.9980</td>
</tr>
<tr>
<td>Region 2</td>
<td>AR, CO, ID, IA, KS, LA, ME, MI, MN, MS, NE, NH, NM, NC, ND, OH, WI, WY</td>
<td><a href="https://colville.com/">https://colville.com/</a></td>
<td><a href="mailto:info@colville.com">email: info@colville.com</a></td>
<td>1.800.390.2500</td>
</tr>
<tr>
<td>Region 3</td>
<td>CA, FL, GA, ND, SC, TN, TX, VA, WV, Puerto Rico and U.S. Virgin Islands</td>
<td><a href="https://colville.com/">https://colville.com/</a></td>
<td><a href="mailto:info@colville.com">email: info@colville.com</a></td>
<td>1.888.360.2500</td>
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<td>Region 4</td>
<td>AK, AZ, DC, DE, HI, ID, IN, MA, MD, MI, ME, NJ, NY, OH, PA, SD, TN, WI, WV, American Samoa and Northern Mariana</td>
<td><a href="https://hmb.com/">https://hmb.com/</a></td>
<td><a href="mailto:info@hmb.com">email: info@hmb.com</a></td>
<td>Part A: 1-500-500-5550; Part B: 1-866-291-7776</td>
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<td>Region 5</td>
<td>Nationwide</td>
<td><a href="https://omc-hmhosac.com">https://omc-hmhosac.com</a></td>
<td><a href="mailto:info@omc-hmhosac.com">email: info@omc-hmhosac.com</a></td>
<td>1.800.291.9980</td>
</tr>
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**Taking the Business of Medicine to the Next Level**

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**RACs**

Recovery Audit Contractors

**Region 4**

HMB Federal Solutions

**Region 1**

Performance Recovery, Inc.

**Region 2**

Colville, LLC

**Region 3**

Performance Recovery, Inc.

**Region 5**

OMC/HMO/OSAC

RACs in Regions 1-4 will perform post payment review to identify and correct Medicare claims specific to Part A and Part B.

Region 5 RAC will be dedicated to review of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) and Home Health / Hospice.

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**Taking the Business of Medicine to the Next Level**
ZPICs
Zone Program Integrity Contractors

• This is the group, formerly known as Program Safeguard Contractors (PSCs), serve the same jurisdictions as the Medicare Administrative Contractors.

• The ZPICs are authorized to conduct investigations, provide support to law enforcement and conduct audits of Medicare advantage plans.

ZPICs
Zone Program Integrity Contractors

• According to the Medicare Program Integrity Manual, Chapter 2, the goals of the ZPICs data analysis program are to identify provider billing practices and services that pose the greatest financial risk to the Medicare program.

• Some ZPICs will concentrate on various Medicare billing "hot" targets.
MICs
Medicaid Integrity Contractors

• Will review Medicaid claims to see whether inappropriate payments or fraud may have occurred. In addition, the MICs will audit Medicaid claims and identify overpayments and areas of high risk for payment errors or fraud. Similar to the RACs, the MICs will use a data-driven approach to focus efforts on aberrant billing practices.

MICs
Medicaid Integrity Contractors

• MICS also will review medical records to verify that paid claims were for the following services:
  – Services actually provided and properly documented in accordance with medical necessity;
  – Services billed properly, using correct and appropriate diagnosis and procedure codes;
  – Covered services; and
  – Services paid for in accordance with federal and state laws, regulations and policies.
MACs
Medicare Administrative Contractors

• These are the groups that process claims for both Part A and Part B services. These groups are charged with overseeing claim completion and accuracy in addition to determining correct payments for services. Since MACs review both facilities' Part A claims and the professional provider Part B claims related to the same beneficiaries and services, CMS feels that the MACs will be able to review discrepancies between the two sets of claims, revise payments and/or increase denials.

Components of E&M Services

• Key Components
  – History (S)
  – Examination (O)
  – Medical Decision Making (A/P)

• Contributory Components
  – Counseling
  – Coordination of Care
  – Nature of Presenting Problem
  – Time
Aspects of Patient Care and Documentation

• Documentation is an important aspect of patient care and is used to:
  – Coordinate services among medical professionals
  – Furnish sufficient services
  – Improve patient care
  – Comply with regulations
  – Support claims billed
  – Reduce improper payment

Medical Record Documentation

• Medical Record Documentation 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
  – date and legible identification of the observer(signature)
Medical Record Documentation

• Medical Record Documentation should include:
  – rationale for ordering diagnostic and other ancillary services
  – past and present diagnoses
  – appropriate health risk factors
  – the patient's progress, response to and change in treatment, and revision of diagnosis

• Medical Record Documentation should support the CPT® and ICD Codes Reported on the Health Insurance Claim Form or Billing Statement

Taking the Business of Medicine to the Next Level
Documenting History

• The history element requires the documentation of CC, History of Present Illness (HPI), Review of Systems (ROS) and Past Family and Social History (PFSH).

• You may list the CC, ROS, and PFSH as separate elements of history or you may include them in the description of the HPI.

• Every visit requires a CC.

Pay attention to the Chief Complaint

• Clearly document chief complaint
  – When auditors, pick up a case, the first thing they are likely to look at is the CC or the reason for the visit.
  – To a significant extent, that is going to drive the overall E/M level. In the follow-up visit a week later, the patient may report other problems.
  – However, the auditor would still look at the CC as the baseline, and this will direct his continuation of care.
**History - Putting it all Together**

*History Table*

*(All 3 must meet at same level/type regardless of patient type)*

ROS may be obtained by ancillary staff | If Unable to obtain history note why

<table>
<thead>
<tr>
<th>HPI</th>
<th>ROS</th>
<th>PFSH</th>
<th>TYPE of History</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief (1-3 elements)</td>
<td>N/A</td>
<td>N/A</td>
<td>Problem Focused</td>
</tr>
<tr>
<td>Brief (1-3 elements)</td>
<td>Problem Pertinent (1 system)</td>
<td>N/A</td>
<td>Expanded Problem Focused</td>
</tr>
<tr>
<td>Extended (4 or more)</td>
<td>Extended (2-9 systems)</td>
<td>Pertinent</td>
<td>Detailed</td>
</tr>
<tr>
<td>Extended (4 or more)</td>
<td>Complete (10 systems)</td>
<td>Complete</td>
<td>Comprehensive</td>
</tr>
</tbody>
</table>

**Documenting the Exam**

- Physicians should develop a strong background in the differences between the 1995 and 1997 E/M documentation guidelines. One of the problem areas for physicians is knowing the difference between the two, often leading to a mix of the two guidelines.
- The most substantial differences in the 1995 and 1997 versions of the documentation guidelines occur in the examination documentation section.
- CMS has indicated that a provider may use either version of the documentation guidelines for a patient encounter, not a combination of the two.
Documenting the Exam

• The 1995 exam guidelines are not clear and leave a lot to auditor interpretation.
  – The type and extent of the examination performed is based on clinical judgment, the patient’s history, and nature of the presenting problem(s).
  – There is not a clear define amount of information needed for a “limited exam”, “extended exam” or “general multi-system”, what might me consider limited, extended or multi might mean something different to someone else. Making the 1995 guidelines a risk for providers to use.

• The 1997 documentation guidelines are based upon clear guidelines and elements that need to be documented for each level of service exam.

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Head and Face</td>
<td>Constitutional</td>
</tr>
<tr>
<td>Neck</td>
<td>Eyes</td>
</tr>
<tr>
<td>Chest, including breast and axillae</td>
<td>Ears, nose, mouth, throat</td>
</tr>
<tr>
<td>Abdomen</td>
<td>Cardiovascular</td>
</tr>
<tr>
<td>Genitalia, groin, buttocks</td>
<td>Respiratory</td>
</tr>
<tr>
<td>Back, including spine</td>
<td>Gastrointestinal</td>
</tr>
<tr>
<td>Each extremity</td>
<td>Genitourinary</td>
</tr>
<tr>
<td></td>
<td>Musculoskeletal</td>
</tr>
<tr>
<td></td>
<td>Skin</td>
</tr>
<tr>
<td></td>
<td>Neurologic</td>
</tr>
<tr>
<td></td>
<td>Psychiatric</td>
</tr>
<tr>
<td></td>
<td>Hematologic, lymphatic, immunologic</td>
</tr>
</tbody>
</table>
Medical Necessity and Medical Decision Making (MDM)

- You should not use the volume of documentation to determine which specific level of service to bill.
- MDM is important, as it drives medical necessity.
- The overarching issue for E/M for any coding documentation is going to be medical necessity.
- It’s in MDM that you have the opportunity to convince a third-party payer that the provider’s actions were justified and appropriate.

Documenting the Medical Decision Making

- Many times physicians choose a code and determine the E/M level based on how heavy the case feels.
- There is a tendency to claim a Level 4 E/M service, when at best the documentation supports a Level 2.
- MDM is based upon 3 Factors:
  1. Number of diagnosis and/or Management Options
  2. Amount and/or Complexity of Data
  3. Risk
Documenting the Medical Decision Making

- Of the three key components, MDM is probably the most important. CPT® has a decision-making matrix which physicians may not tend to utilize as much as they should.

- A provider must attain two out of three components for eligibility to report the type of medical decision-making level.

- While it is typically assumed that this table is subjective, in actuality there is a method used by auditors when deciding what Minimal, Limited, Multiple and Extensive is related to.

<table>
<thead>
<tr>
<th># DXs Manage Options</th>
<th>Amount Data For Review</th>
<th>Risk of Complications (Based on the Table of Risk)</th>
<th>Type of Medical Decision Making</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal 1 pt</td>
<td>None/Min 1pts</td>
<td>Minimal</td>
<td>Straightforward</td>
</tr>
<tr>
<td>Limited 2pts</td>
<td>Limited 2pts</td>
<td>Low</td>
<td>Low Complexity</td>
</tr>
<tr>
<td>Multiple 3pts</td>
<td>Moderate 3pts</td>
<td>Moderate</td>
<td>Moderate Complexity</td>
</tr>
<tr>
<td>Extensive 4+pts</td>
<td>Extensive 4+pts</td>
<td>High</td>
<td>High Complexity</td>
</tr>
</tbody>
</table>
Medical Decision Making “Tips”

• When Documenting your diagnosis make sure you indicate:
  – If there is severe exacerbation, progression, or side effects of side effects of treatment
  – Acute or chronic condition that may pose a treat to life or bodily function
  – If the problem is not stable indicate it as, worsening or failing to progress

Medical Decision Making “Tips”

• When Documenting your Management options make sure you indicate:
  – RX with dosage and directions (even if it’s a refill)
  – Any diagnostic procedure, ordered, plan, performed or reviewed.
Questions?

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