Documentation 101: Back to the Basics

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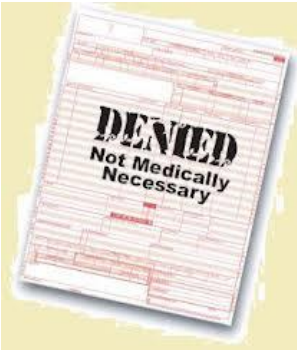
Agenda

- Medical Necessity
- E&M
  - 30,000 foot viewpoint
- Pitfalls and recommendations
  - Check boxes/Macros
  - Copy and paste
  - Templates
  - Auto change of note author
  - Audit trail
  - Dictation
- Who is watching

Medical Necessity



Medical necessity

- Title XVIII of the Social Security Act, Section 1862 (a) (1) (a):
  - "No payment may be made under Part A or Part B for expenses incurred for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."
- Per CMS – Medicare Claims Processing Manual –
  - Medical necessity 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."

Reasonable and Necessary

- Contractors shall describe in the draft LCD the circumstances under which the item or service is reasonable and necessary under 1862(a)(1)(A). Contractors shall consider a service to be reasonable and necessary if the contractor determines that the service is:
  - Safe and effective;
  - Not experimental or investigational (exception: routine costs of qualifying clinical trial services with dates of service on or after September 19, 2000 which meet the requirements of the Clinical Trials NCD are considered reasonable and necessary); and
  - Appropriate, including the duration and frequency that is considered appropriate for the item or service, in terms of whether it is:
  - Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition or to improve the function of a malformed body member;
  - Furnished in a setting appropriate to the patient's medical needs and condition;
  - **Ordered and furnished by qualified personnel;**
  - **One that meets, but does not exceed, the patient's medical need; and**
  - **At least as beneficial as an existing and available medically appropriate alternative.**

    (Chapter 13, sec. 13.5.1)

Documenting Medical Necessity

- Paint a picture
- Write in such a way the patient/guardian could understand what services are provided
- Do not simply list diagnoses
  - Document progress/improvement or lack of either
- Know your NCD/LCDs or payor policies
  - Document to these base standards
- Clearly substantiate the condition being treated, how it was treated and why the treatment was chosen

Evaluation & Management

History

- Chief Complaint
  - A concise statement, in the patient's own words, describing the reason for the encounter. **Each note must always include a chief complaint.**
- 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.
- A ROS and/or a PFSH obtained during an earlier encounter does not need to be rerecorded 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 discussion and/or review of a new complaint should be documented

History

- 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.
- 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.
- 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.

Examination

- Specific abnormal and relevant negative findings of the examination of the affected or symptomatic body area(s) or organ system(s) **should be documented**.
- A notation of "abnormal" without elaboration is not sufficient. Abnormal or unexpected findings of the examination of any asymptomatic body area(s) or organ system(s) **should be described.**
- A brief statement or notation indicating "negative" or "normal" is sufficient to document normal findings related to unaffected area(s) or asymptomatic organ system(s)

Medical Decision Making

- Most often plays the primary role in determining the correct level of service E/M code.
- Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by:
  - 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
  - The risk of significant complications, morbidity and/or mortality
  - Comorbidities, associated with the patient's presenting problem(s), the diagnostic procedure(s) and/or the possible management options

Medical Decision Making

- If a diagnostic service is ordered, planned, scheduled, or performed at the time of the E/M encounter, the type of service should be documented.
- The review of laboratory, radiology, and/or other diagnostic tests should be documented. A simple notation such as "WBC elevated" or "Chest x-ray unremarkable" is acceptable. Alternatively, the review may be documented by initialing and dating the report that contains the test results.
- A decision to obtain old records or obtain additional history from the family, caretaker, or other source to supplement information obtained from the patient should be documented.
- Relevant findings from the review of old records and/or the receipt of additional history from the family, caretaker, or other source to supplement information obtained from the patient should be documented. If there is no relevant information beyond that already obtained, this fact should be documented. A notation of "Old records reviewed" or "Additional history obtained from family" without elaboration is not sufficient.
- Discussion about results of laboratory, radiology, or other diagnostic tests with the physician who performed or interpreted the study should be documented.
- The direct visualization and independent interpretation of an image, tracing, or specimen previously or subsequently interpreted by another physician should be documented

Medical Decision Making

- Comorbidities/underlying diseases or other factors that increase the complexity of medical decision making by increasing the risk of complications, morbidity, and/or mortality should be documented;
- If a surgical or invasive diagnostic procedure is ordered, planned, or scheduled at the time of the E/M encounter, the type of procedure should be documented;
- If a surgical or invasive diagnostic procedure is performed at the time of the E/M encounter, the specific procedure should be documented; and
- The referral for or decision to perform a surgical or invasive diagnostic procedure on an urgent basis should be documented or implied

Pitfalls

Pitfalls

- *Check Boxes*
  - Provides limited options and/or space for the collection of information
  - Predefined answers, limited space to enter information, etc.
  - CMS discourages the use of such templates.
  - Claim review experience shows that that limited space templates often fail to capture sufficient detailed clinical information to demonstrate that all coverage and coding requirements are met
    - (Medicare Program Integrity Manual," Chapter 3, Section 3.3.2.1.1)
- *Macros (charting by exception)*
  - Expanded text that is triggered by abbreviated words or keystrokes
  - Macros allow users to generate a lot of documentation with one click.

Pitfalls

- *Over documentation*
  - 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 or word, which if not appropriately edited by the provider, may be inaccurate
  - May suggest the practitioner preformed more comprehensive services than were actually rendered
    - (OIG, December 2013, "Not All Recommended Fraud Safeguards Have Been Implemented in Hospital EHR Technology")

Pitfalls

- *Check boxes/Macros*
- May encourage over-documentation to meet reimbursement requirements
  - Even when services are not medically necessary or are never delivered
- Documentation can be produced for services not rendered
- Either may cause upcoding (higher level of service than provided)

Recommendations

- Policies:
  - Should require the provider to review and edit all defaulted data to ensure that only patient-specific data for that visit is recorded.
  - Control structures that require the addition of free text when auto-population methods are used
  - Should require the provider to verify the validity of information on entry
- Providers
  - Should verify the validity of auto-populated information on entry and delete all irrelevant and unnecessary auto-populated information.
  - Should avoid the generation of a note that does not require some action on the part of the provider

Pitfalls

- *Copy-Pasting*
  - Copy-pasting, also known as cloning, allows 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
  - 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
    - (OIG, December 2013, "Not All Recommended Fraud Safeguards Have Been Implemented in Hospital EHR Technology")

Pitfalls

- *Copy-Pasting*
  - Can lead to redundant/inaccurate information in EHRs.
  - Authorship integrity
    - Documentation cannot be tracked to the original source
  - Lacks patient-specific information necessary to support services rendered to each patient.
  - Can effect quality of care /improper payments due to:
    - Potentially false impression of services provided to the patient
    - Coding from old or outdated information that may lead to "upcoding"

Recommendations

- Policies
  - Weigh efficiency against potential for inaccurate, fraudulent or unmanageable documentation
  - Should require the provider to modify copied information to be patient-specific and related to the current visit
  - Limit the use of the copy and paste function
  - Monitor and audit usage of this feature
  - Prohibit the use of 'cut and paste'

Recommendations

- Providers must :
  - Recognize each encounter as a stand-alone record
  - Ensure the documentation for that encounter reflects the level of service actually provided
  - Meets payer requirements for billing and reimbursement
  - Document to paint a picture of the current encounter.
  - Document the history of present illness (HPI) based on the patient's current information, adding notes such as, "since last seen, he reports …."
- Each entry not solely authored by the user must be:
  - Validated in a manner similar to bibliographic notations
  - Include the name, date, time, and source of the data.
  - This can be satisfied by system software design that routinely provides validation

Pitfalls

- *Template*
  - Documentation tools that feature predefined text/options used
  - May create a liability for false claims as the additional documentation may lead to upcoding
  - May cause issues if the template does not fit the clinical needs of the provider
  - Could encourage over-documentation
- *Automated change of note author*
  - Automatically changing authorship of a note written by someone else to the current user of the note
  - May be impossible to verify who performed the service

Recommendations

- Policies:
  - Use 'open-ended' templates, allowing check boxes for general information
  - Require the practitioner to provide additional patient-specific information about the current condition being provided
  - 'Signature cards' should be kept in order to identify the practitioner accurately.
- Providers
  - Must understand the value in reviewing/editing all default data
  - Adopt an EHR system which will allow more than one author in a single document
  - Preserve the authorship of each entry to the correct individual
  - Creating a way to verify the actual service provider or the amount of work performed by each provider

Pitfalls

- *Audit trail*
  - Audit trails:
    - Record all activity
    - Logs EHR access (where, when, how)
    - Logs amendments, corrections, deletions - including date/time
  - EHR systems allow these functions to be turned off
    - Creates an incomplete audit trail

Recommendations

- The HIPAA Security Rule, 45 C.F.R § 164.312(b), mandates that the audit trail be maintained within the EHR
- HHS-OIG)has stated that the EHR system's audit log should always be turned on

- Policies
  - Must require the audit trail remain operational
    - Except when authorized by an administrator for–
      - system upgrades/fixes
      - Disaster recovery

Pitfalls

- *Dictation/scribes/voice to text*
  - Provider dictates notes to a recorder or scribe, or uses voice-to-text software for documenting the patient visit
  - When entered in by someone other than the provider, the information may be incorrect
  - Nonvalidation entered by others may not support claim

Recommendations

- Policies:
  - Require the provider of the service should review, edit and authenticate the documentation by signature in a timely manner.

Who is Watching?

Who is watching ?

- Macs –
  - Responsible primarily for processing and paying Medicare claims.
  - Collaborate with CMS to ensure appropriate payment
  - Educate providers on billing and documentation requirements
  - Detects Fraud
- RACS –
  - RACs are responsible primarily for identifying and reducing Medicare improper payments
    - detecting and recouping improper payments
- ZPICs –
  - Responsible primarily for detecting and deterring Medicare fraud.
  - Investigate providers that have filed potentially fraudulent claims
    - variety of methods
    - Prepayment reviews
    - Post payment reviews
    - onsite audits.
  - Recommend that CMS or MACs revoke the billing privileges of providers.

Who is watching ?

- OIG – Office of Inspector General
  - Fights waste, fraud and abuse in Medicare, Medicaid and more than 100 other HHS programs.
- CERT – Comprehensive Error Rate Testing
  - Improper Payment Measurement in the Medicare Fee-for-Service Program
  - Improper Payment Categories
    - No Documentation
    - Insufficient Documentation
    - Medical Necessity
    - Incorrect Coding
    - Other

References

- www.CMS.gov
- www.OIG.gov
- Ensuring Proper Use of Electronic Health Record. (2015, July). Retrieved April 18, 2016, from https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/ehr-decision-table.pdf
- 1995/1997 E&M guidelines

Thank you

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AVP Compliance & Process Improvement