Compliant Documentation for Coding and Billing
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Disclaimer

Information contained in this text is based on CPT®, ICD-9-CM and HCPCS rules and regulations. However, application of the information in this text does not guarantee claims payment. Payers’ interpretation may vary from those found in this text. Please note that the law, applicable regulations, payer’ instructions, interpretations, enforcement, etc., may change at any time. Therefore, it is crucial to stay current with all local and national regulations and policies.
What are the Tools?

- Documentation Guidelines - Medicare
- AMA/CPT Code Descriptions
- OIG Compliance Guidance
- MACs
What are the Tools?

OPINIONS?
READ THE GUIDELINES – Medicare Documentation Guidelines

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.
Documentation: Basic Requirements

READ THE GUIDELINES - Medicare Documentation Guidelines

1. The medical record should be complete and legible.

2. The documentation of each patient encounter should include:
   a) reason for the encounter and relevant history, physical examination (history and exam)
   b) findings and prior diagnostic test results; (MDM)
   c) assessment, clinical impression or diagnosis; (MDM)
   d) plan for care; and (MDM)
   e) date and legible identity of the observer.
READ THE GUIDELINES - Medicare Documentation Guidelines

3. If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred. (MDM)

4. Past and present diagnoses should be accessible to the treating and/or consulting physician.

5. Appropriate health risk factors should be identified. (MDM)
READ THE GUIDELINES – Medicare Documentation Guidelines

6. The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented. (MDM)

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.
READ THE GUIDELINES - Medicare Documentation Guidelines

8. The ROS and/or PFSH may be recorded by ancillary staff (or a student) 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. *(History)*
READ THE GUIDELINES - OIG Compliance Policy for Physician Practices

Medical Record Documentation. In addition to facilitating high quality patient care, a properly documented medical record verifies and documents precisely what services were actually provided. The medical record may be used to validate: (a) The site of the service; (b) the appropriateness of the services provided; (c) the accuracy of the billing; and (d) the identity of the care giver (service provider).
The following are the signature requirements that the claims reviewers will apply: (Other regulations and the Centers for Medicare & Medicaid Services (CMS) instructions, regarding signatures (such as timeliness standards for particular benefits), take precedence).
Documentation: Signatures

• **Definition of a handwritten signature:** This is a mark or sign by an individual on a document to signify knowledge, approval, acceptance, or obligation.

• **Definition of a Signature Log:** Providers will sometimes include, in the documentation they submit, a signature log that identifies the author associated with initials or an illegible signature. The signature log might be included on the actual page where the initials or illegible signature are used or might be a separate document. In order to be considered valid for Medicare medical review purposes, the log must be a part of the patient’s medical record. Reviewers will consider all submitted signature logs, regardless of the date it was created.
The History

• Who can document the CC, HPI, ROS, PFSH
  – Who does?
• How much is enough
• “In for follow-up”
• What is really the difference between the EPF and D history?
• What is really the difference between the D and C history?
Evaluation and Management Services
Credit for Work Done

99213
EPF (history and exam), Low MDM

99214
D (history and exam), Mod MDM

Only 2 out of 3 requirements needed
The Exam

• Does there have to be one?
  – Who says?

• How much is enough?

• Which one to use?
  – 1995 or 1997
  – BA and OS...the debate or just count the bullets?
The Exam

• Should the coder/auditor suggest more/less exam?
• Medical Necessity and the EHR/EMR?
Medical Decision Making

• Does the assessment have anything to do with the history?
  – Does it have to?

• Is it an assessment or a problem list?
  – What’s the difference?

• Status of conditions

• Treatment plans
Time

• What is the rule?
• What must be documented?
• When does it have to be a part of the medical record?
Evaluation and Management Services
Credit for Work Done

- Coding Based on Time
  
  **Office and outpatient scenarios**
  
  If over 50% of the face-to-face time is spent in counseling and coordination of care then time may be used as the indicator for the code selection.

**NOT DOCUMENTED NOT DONE**
Evaluation and Management Services
Credit for Work Done

• Coding Based on Time

Unit/floor Time
If over 50% of the floor/unit time is spent in counseling and coordination of care then time may be used as the indicator for the code selection.

Hospital observation, inpatient hospital, inpatient consultations, nursing facility

NOT DOCUMENTED NOT DONE
Time for Office E/M (in minutes)

99201 – 10  
99202 – 20  
99203 – 30  
99204 – 45  
99205 - 60  

99212 -10  
99213 - 15  
99214 - 25  
99215 - 40
## Time for Inpt E/M (in minutes)

<table>
<thead>
<tr>
<th>Admit</th>
<th>Subsequent</th>
</tr>
</thead>
<tbody>
<tr>
<td>99221 – 30</td>
<td>99231 -15</td>
</tr>
<tr>
<td>99222 – 50</td>
<td>99232 - 25</td>
</tr>
<tr>
<td>99223 – 70</td>
<td>99233 – 35</td>
</tr>
</tbody>
</table>
PATH Guidelines

Medicare Claims Processing Manual

Chapter 12

Section 100
PATH - Resident

An individual who participates in an approved graduate medical education (GME) program or a physician who is not in an approved GME program but who is authorized to practice only in a hospital setting.

The term includes interns and fellows in GME programs recognized as approved for purposes of direct GME payments made by the FI.
PATH - Student

An individual who participates in an accredited educational program (e.g., a medical school) that is not an approved GME program.

A student is never considered to be an intern or a resident.

Medicare does not pay for any service furnished by a student.
PATH - Teaching Physician

A physician (other than another resident) who involves residents in the care of his or her patients.
PATH - Critical or Key Portion

That part (or parts) of a service that the teaching physician determines is (are) a critical or key portion(s). For purposes of this section, these terms are interchangeable.
Notes recorded in the patient's medical records by a resident, and/or teaching physician or others as outlined in the specific situations below regarding the service furnished.

Documentation may be dictated and typed or hand-written, or computer-generated and typed or handwritten.

Documentation must be dated and include a legible signature or identity.

Pursuant to 42 CFR 415.172 (b), documentation must identify, at a minimum, the service furnished, the participation of the teaching physician in providing the service, and whether the teaching physician was physically present.
For a given encounter, the selection of the appropriate level of E/M service should be determined according to the code definitions in the American Medical Association’s Current Procedural Terminology (CPT) and any applicable documentation guidelines.
For purposes of payment, E/M services billed by teaching physicians require that they personally document at least the following:

- That they performed the service or were physically present during the key or critical portions of the service when performed by the resident; and
- The participation of the teaching physician in the management of the patient.
PATH
Evaluation and Management

*Documentation by the resident of the presence and participation of the teaching physician is not sufficient to establish the presence and participation of the teaching physician.*
PATH
Evaluation and Management

On medical review, the combined entries into the medical record by the teaching physician and the resident constitute the documentation for the service and together must support the medical necessity of the service.
Scenario #1

The teaching physician personally performs all the required elements of an E/M service without a resident.

In this scenario the resident may or may not have performed the E/M service independently.

In the absence of a note by a resident, the teaching physician must document as he/she would document an E/M service in a nonteaching setting.

Where a resident has written notes, the teaching physician’s note may reference the resident’s note. The teaching physician must document that he/she performed the critical or key portion(s) of the service, and that he/she was directly involved in the management of the patient.
Evaluation and Management

Unacceptable Documentation

• “Agree with above.”, followed by legible countersignature or identity;

• “Rounded, Reviewed, Agree.”, followed by legible countersignature or identity;

• “Discussed with resident. Agree.”, followed by legible countersignature or identity;
PATH

Evaluation and Management

Unacceptable Documentation

• “Seen and agree.”, followed by legible countersignature or identity;

• “Patient seen and evaluated.”, followed by legible countersignature or identity; and

• A legible countersignature or identity alone.
Such documentation is not acceptable, because the documentation does not make it possible to determine whether the teaching physician was present, evaluated the patient, and/or had any involvement with the plan of care.
Any contribution and participation of a student to the performance of a billable service (other than the review of systems and/or past family/social history which are not separately billable, but are taken as part of an E/M service) must be performed in the physical presence of a teaching physician or physical presence of a resident in a service meeting the requirements set forth in this section for teaching physician billing.
Student Documentation

The documentation of an E/M service by a student that may be referred to by the teaching physician is limited to documentation related to the review of systems and/or past family/social history.
The teaching physician may not refer to a student’s documentation of physical exam findings or medical decision making in his or her personal note.

If the medical student documents E/M services, the teaching physician must verify and re-document the history of present illness as well as perform and re-document the physical exam and medical decision making activities of the service.
Time Based Codes – PATH Rules

For procedure codes determined on the basis of time, the teaching physician must be present for the period of time for which the claim is made. For example, a code that specifically describes a service of from 20 to 30 minutes may be paid only if the teaching physician is physically present for 20 to 30 minutes.
Diagnosis Coding
Correct Diagnosis Coding

Basic Documentation Rules to Code by for Physician Practices

When coding from the medical record or source document only code those items clearly stated; DO NOT code anything listed as

- “possible”,
- “probable”,
- “maybe”,
- “suspected”
Correct Diagnosis Coding

Basic Documentation Rules to Code by for Physician Practices

There are no “rule-out” codes
Correct Diagnosis Coding

Basic Documentation Rules to Code by for Physician Practices

Be as specific as possible; code acute conditions as “acute” and chronic conditions as “chronic”

And be sure they are noted that way in the chart
Correct Diagnosis Coding

Basic Documentation Rules to Code by for Physician Practices

When a concise diagnosis cannot be made, code based on signs and symptoms.

✗ Signs and symptoms do not have to be separately listed if they are an integral part of the underlying diagnosis or condition already coded.
Correct Diagnosis Coding

Basic Documentation Rules to Code by for Physician Practices

• Additional signs and symptoms that *may not be associated routinely* with a disease process should be coded when present.

• Code for any and all conditions that were treated or affected treatment.
Correct Diagnosis Coding

Basic Documentation Rules to Code by for Physician Practices

Be sure to code all manifestations and complications.

SEVERITY & MEDICAL NECESSITY
Correct Diagnosis Coding

Basic Documentation Rules to Code by for Physician Practices

It is the responsibility of the provider of care to link the diagnosis to the CPT code whether it be on the encounter form or whatever “billing” form is in use.

Incorrect linkage leads to denials based on medical necessity.
Correct Diagnosis Coding

Basic Documentation Rules to Code by for Physician Practices

Personal history (V-codes) explain a patient’s past medical condition that
– No longer exists
– Is not receiving any treatment
– Has the potential for recurrence
RAC Coding Issues

How you can avoid “The Letter”
Modifiers

**Modifier 24 – Unrelated Evaluation and Management Service by the Same Physician During a Postoperative Period**

- Modifier is used on E&M codes ONLY.
- Same provider (or group) as the surgery
- Separate diagnosis codes are NOT required
Modifiers

**Modifier 25** – Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the same Day of the Procedure or Other Service

- Modifier is used on E&M codes ONLY.
- Same provider as the MINOR surgery (10 day global).
- Separate diagnosis codes are NOT required; per CMS and AMA.
- Submission of documentation may be required by some third party carriers.
Place of Service

Relative Value Unit (RVU)

• Provider work
• Overhead (facility)
• Risk
Place of Service

- Office
- Provider Based
- Outpatient Hospital
- Inpatient Hospital

Who owns the overhead? If it is the facility, the provider should not be paid for that part of the total RVU.
Remember to consider all the rules not just those that determine a level of service.

Thank you

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