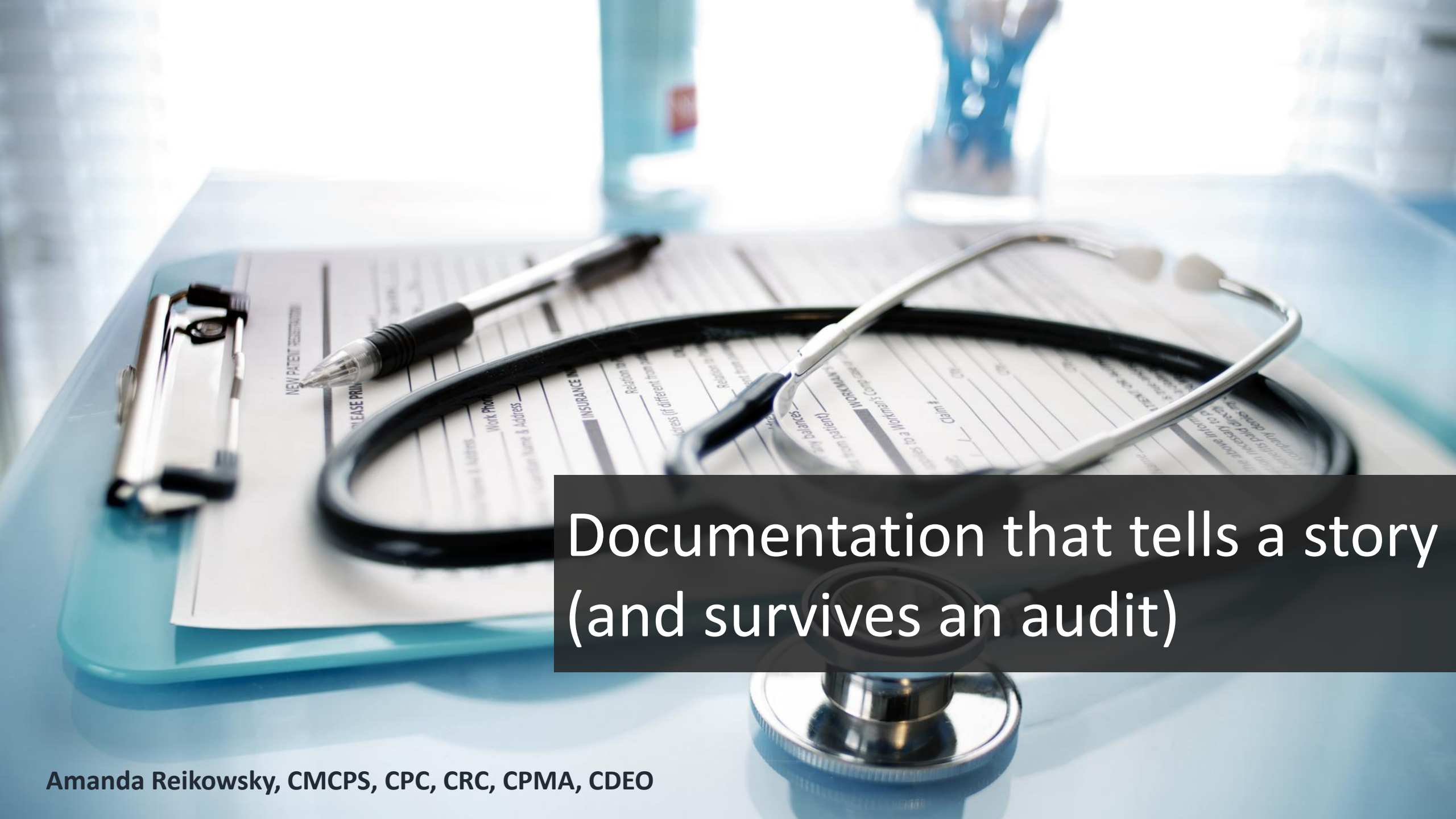

Documentation that tells a story (and survives an audit)

Amanda Reikowsky, CMCPS, CPC, CRC, CPMA, CDEO

Disclaimer

The information provided in this webinar is accurate as of the presentation date. However, coding guidelines, procedures, and regulations are subject to change. Updates or new guidelines from the American Medical Association (AMA) or other authoritative bodies may affect the content presented.

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Participants are responsible for verifying the information presented and confirming with local payors and Medicare Administrative Contractors (MACs) before making any changes to their coding practices or workflows.

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Agenda

- **Medical Decision Making**
- **Time, Teams, and Teaching**
- **Bad Habits & Template Tuning**
- **Delivering Education**

Introduction

Supervisor, Coding Quality Audit/Education Team

CMCPS, CPC, CRC, CPMA, CDEO

Industry Speaker → *That's Healthcon in Orlando!*

Owner: CodeWise Solutions LLC

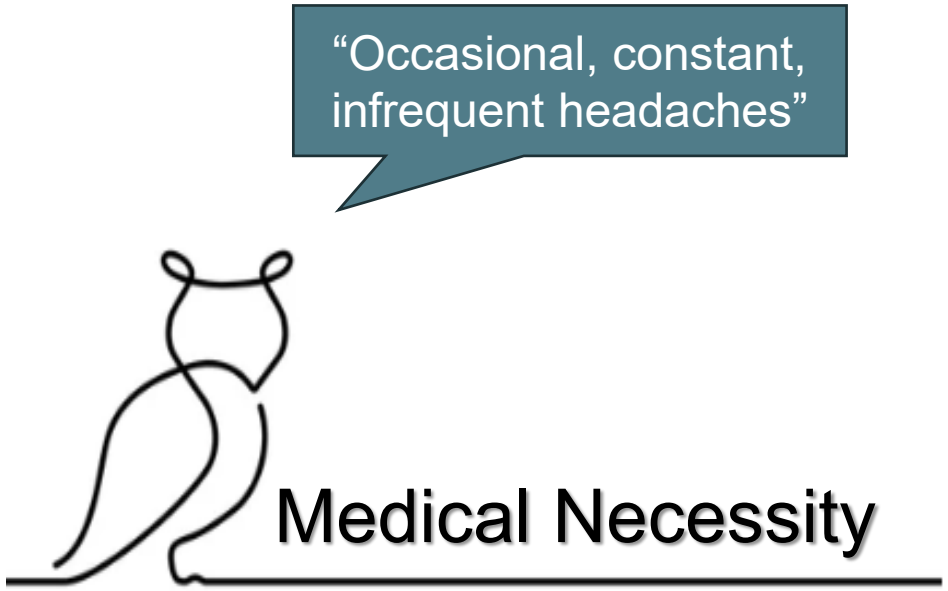
- Auditing Projects
- Educational Seminars/Webinars
- Medical Cost Projections

CodeWise SOLUTIONS

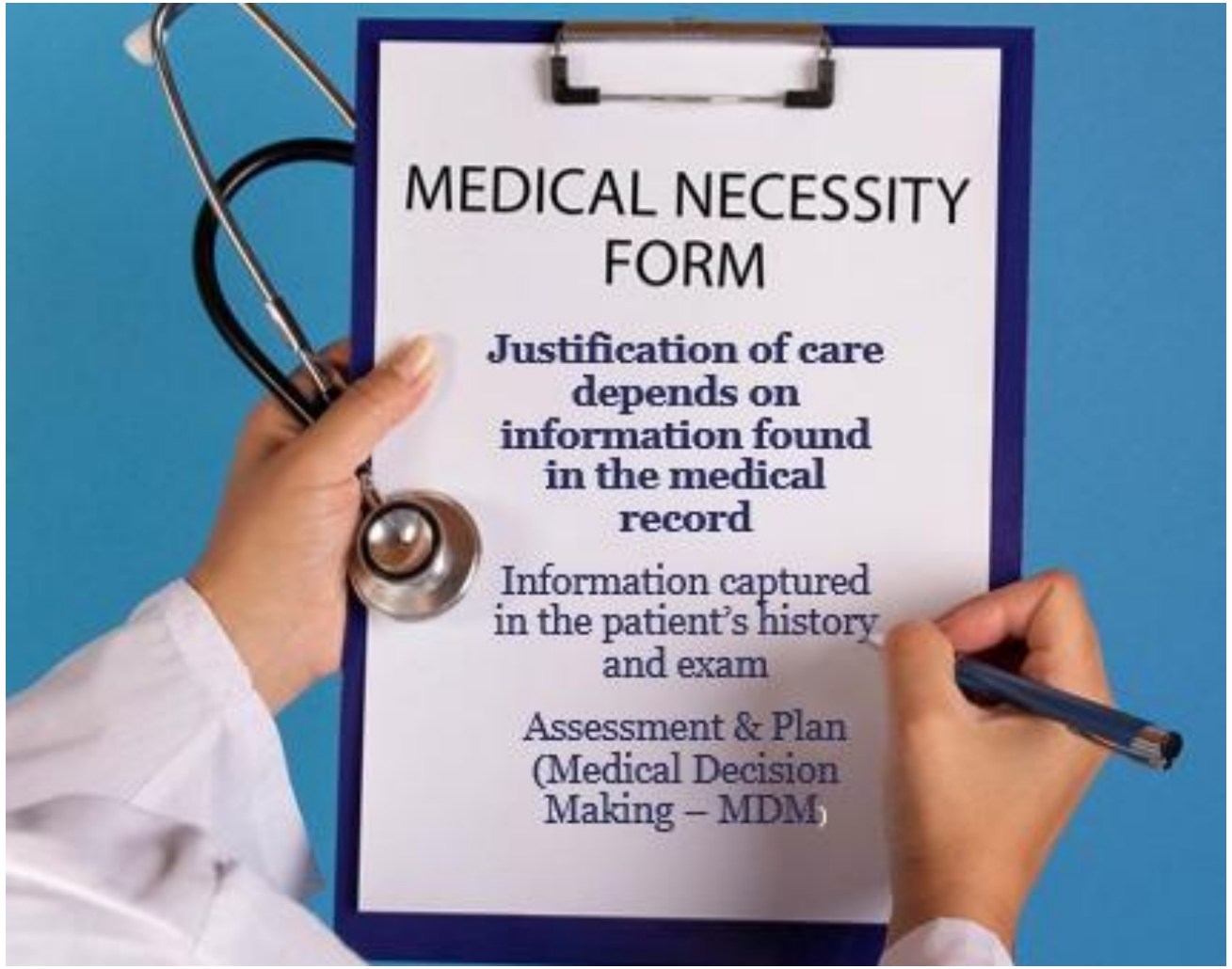
"She is numb from her toes down"

Medical
Decision Making

Not **how** to level a service… but how to avoid common mistakes and ensure documentation **supports** the level of service.



Medical Necessity



E/M Documentation

Chief Complaint

Presenting Problem

Establishes medical necessity!

ROS

Not Required

But should you?

When should you include one?

History & Exam

Medically Relevant

Quality, not Quantity

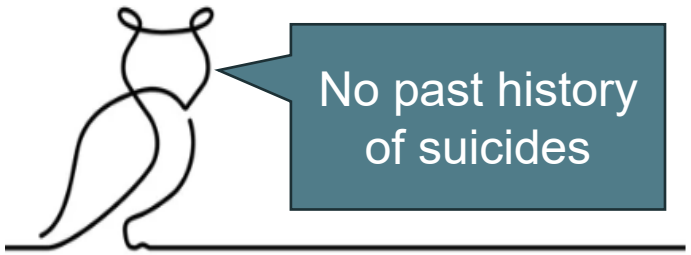
Pertinent to the presenting problem.

Assessment & Plan

Decision Making

Credit for thought process.

MDM Diary



Presenting Problems

M.E.A.T
Managed
Evaluated
Assessed
Treated

Nature of the diagnosis does not equate to any particular level of service!

Status on the day of the visit

Scale from “resolved” to “the worst it can get”.

Stable at goal vs not at goal

At goal = continue current plan.
Not at goal = changes to plan

Complicated vs Uncomplicated

Treated in office or refer to ER?
Simple repair or requires debridement or fixation or “more”

New w/ Uncertain Prognosis

Differential needed to show the uncertainty.

Amount and/or Complexity of Data

Cannot count tests billed for (EKG, x-ray, PFT, etc.)

Exception: POC tests w/o interpretation element (26 modifier

Independent Historian

Medical Necessity and identity of historian

Independent Interpretation

“reviewed” vs “viewed”

Discussion w/ External Provider

Discussed with XXX, and…
How did it affect the plan?

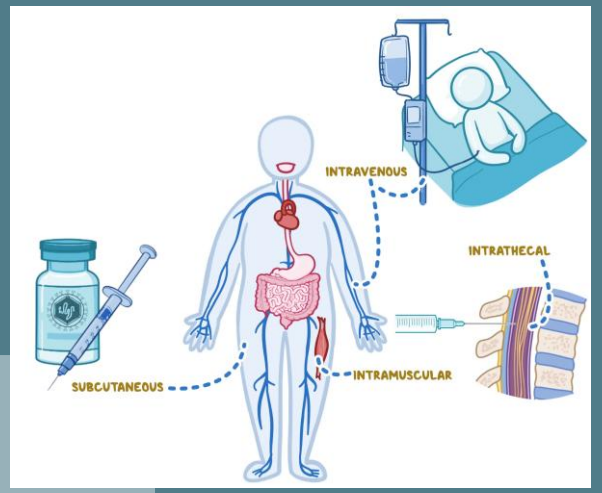
Clinical Significance

How did the results affect management?

Risk of Management

Vague Recommendations

SDOH: Barrier to care plan.



Patient/Procedure Risk Factors

What makes this more of a risk for THIS patient?

Prescription Drug Management

Drug Name, Management taken (sometimes dose)

Monitoring for Toxicity

Link the test to the drug!

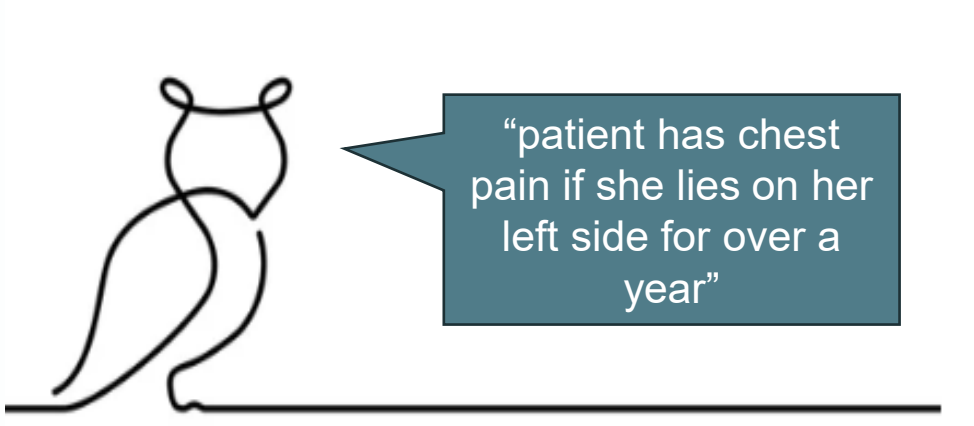
Parenteral Controlled Substance

Who’s managing?

Coding on Time

Per WPS, they accept total time OR start/stop times.

Exclude time spent performing other billable services!



WPS E/M Documentation policy:
https://www.wpsgha.com/guides-resources/view/1225

How to choose? MDM or Time

MDM

- Quick visits
- Elevated risks
- Should be the usual method!
  - >42% of American Adults have at least 2 chronic conditions and are taking at least 1 prescription medication!

Time

- Counseling
- Many treatment options
- Caution: The Impossible Day!
  - DOJ-New Jersey: $700k in take backs due to >40 hours billed in one day
  - DOJ-Massachusetts: on 382 days, psychotherapy was billed for >24 hours. (Sentenced to prison!)

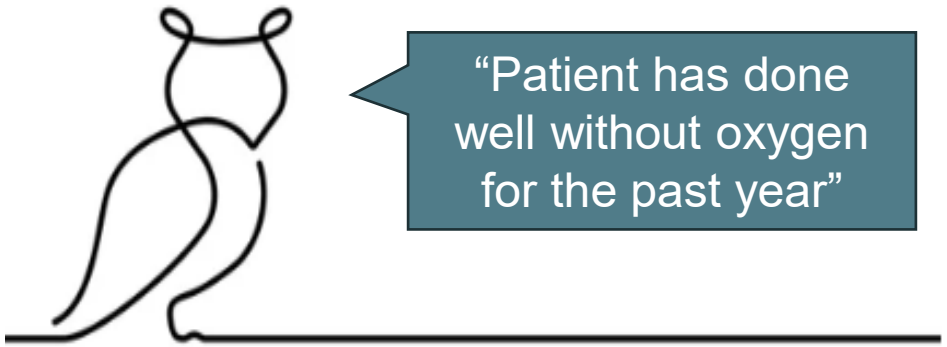
Break Time


TIME FOR A
BREAK


Patient to return in 2 weeks.
Sour Balls


Patient was prepped and raped in the usual sterile fashion.

Teams, Teaching, and Time



Split Shared Services

Time

- Who spent the most “patient care” time
- Both providers document their time
- Time spent together is counted once, by whoever spent more time individually*
- Only one needs to see the patient (regardless of who bills)
- E/M = total time of BOTH providers.
- FS modifier

**Organizational policies have determined shared time should be attributed to the physician.*

MDM

- Billing Provider must document their MDM component in its entirety.
- This determines billing provider, not level of service.
- All documentation can be combined to level the service.
- Only one needs to see the patient (regardless of who bills)
- FS modifier
- Not allowed for critical care or ED services

New patient or New Problem

Supervising Physician sees patient, establishes plan.

Recommend documenting contingencies for various scenarios:
- Adverse effects or allergic reactions.
- If this… then that…

Follow-up with NP/PA

NP/PA continues plan from supervising physician

No deviations from the documented plan! Co-signature IS required.

Change in Plan

Medication adjustments, changes, etc…

The claim would then be billed under the NP/PA's name only.

Physician Involvement

Must stay involved, periodic assessment

"Active participation" not clearly defined. **Per WPS**: "The physician must remain involved in the patient's care. The billing practitioner must provide subsequent services **at such a frequency which reflect active participation** and management of the patient's care."

Incident-to

Office (POS 11) only

This means Provider Based (PBB) clinics cannot do Incident-to services!
(POS 19 and 22)

Documentation Requirements

Documentation must show the NP/PA is following the plan of care (POC) of the billing practitioner. This can include a statement in the records.

POC Changes

Incident to services do not apply to a new patient or a new problem. If the NPP changes the POC, the service is no longer an incident to service.

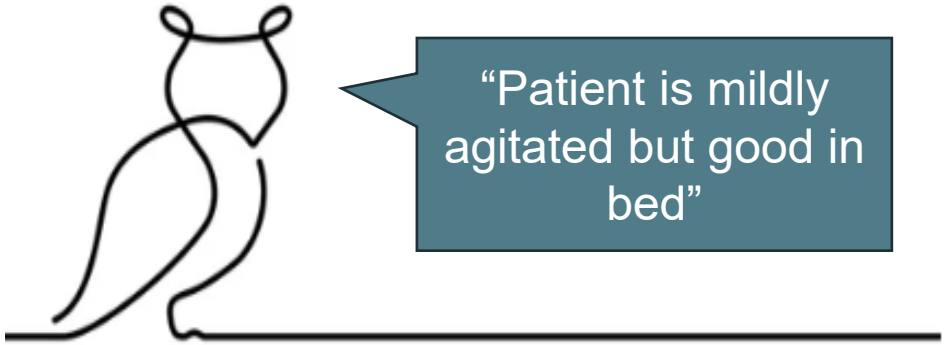
Teaching Physicians and Residents

Documentation Requirements

- Direct Involvement
- Personal Documentation
- Verify Resident's Note
- Signature/Date

Problem Areas

- Conflicting Documentation
- Service Spans a Midnight
- Assistant Surgeons



Time

Total time on the DOS

No longer require >50% counseling or coordination of care.

"*Documentation must clearly reflect the time spent providing the service. Documentation must also support the time described.*"

Per WPS:

- Typical time – must meet the midpoint
  - 15 minutes – would need at least 8 minutes
- At least – must meet the minimum
  - At least 15 minutes (E/M Codes)
- Specific time – must meet the minimum time required
  - Discharges (30 minutes or >30 minutes)
- Cumulative time
  - 30 minutes in a calendar month
- BCBSK: **Start/Stop times preferred**

Telehealth – BCBSK Policy

Allowed

- Audio only or Audio/video E/M and Mental Health
- POS 02 (patient at home) or 10 (patient not at home) with GT modifier

Not Allowed

- PT/OT/SLP & Audiology
- Emails, texts, fax only

National Policy pending Government shut-down resolutions.

Critical Care

Requirements

- Time
- System Failure
- Interventions

Questions to ask in training:

? What would happen without your intervention? (death, organ failure)

? What action, decision, or procedure stabilized or redirected the patient's course?

? You have the minutes, but how was that time critical? Complex decisions? Family discussions for options/consent?

Critical Care by Multiple Providers

Providers

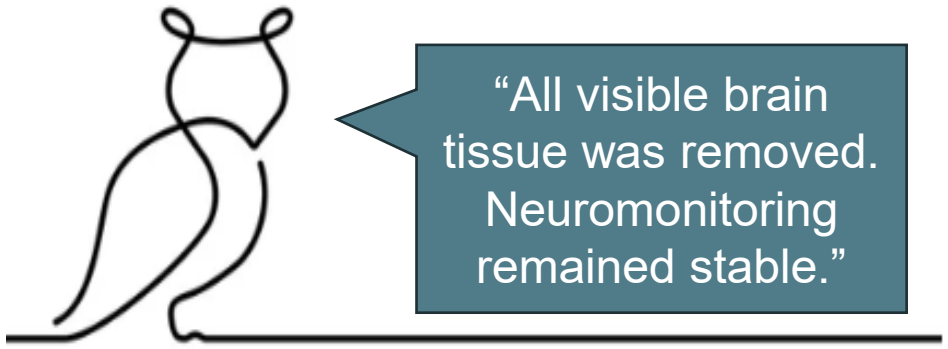
- Same Group
  - Total distinct time on that day.
  - 99292: reported by “same group” provider for their time.
- Different Group
  - 99291 by each specialty group.
  - Diagnosis for condition being managed.

During Post-operative Period

- Unrelated Critical Care
- Separate Diagnosis!
- FT modifier

Tip! If the patient was stable (non-critical) earlier in the day, and then BECOMES critical, the E/M can be reported in addition to the 99291 (with 25 modifier).

Bad Habits & Template Tuning



Templates

- Too specific: Does not apply to all patients
- Too vague: Applies to all patients, but without value
- Bloated notes: HPI, ROS, PFSH, lab and imaging results

This exam was a template used on all patients for 5+ years. He did not realize it was positive for tracheostomy scars.

Patients over Paperwork initiative:

Quality over Quantity!

Objective
VS/Measurements

Temperature:	36.8 using method Oral
BP:	125/81
Pulse:	93
Respiration Rate:	18
SpO2:	98
FIO2:	---
24Hr Tmax:	37.0 using method ---

Weight:

Initial Weight:	73.8 kg 162 lb 03/28
Current Weight:	76.0 kg 167 lb 04/01

General: No acute distress.
HENT: Normocephalic, TM normal.
Neck: Supple, Tracheostomy scar
Respiratory: No wheeze, Respirations are non-labored.
Cardiovascular: Regular rate, Regular rhythm.
Gastrointestinal: Normal bowel sounds, nontender to palpation
Musculoskeletal: Normal range of motion, Normal strength.
Integumentary: Warm, Dry, Intact.
Neurologic: Alert, Oriented, No focal defects.
Psychiatric: Appropriate mood & affect, cooperative.

Template Abuse

Assessment:

- Unstable Gait
- Acute Blood Loss Anemia
- Traumatic Injury

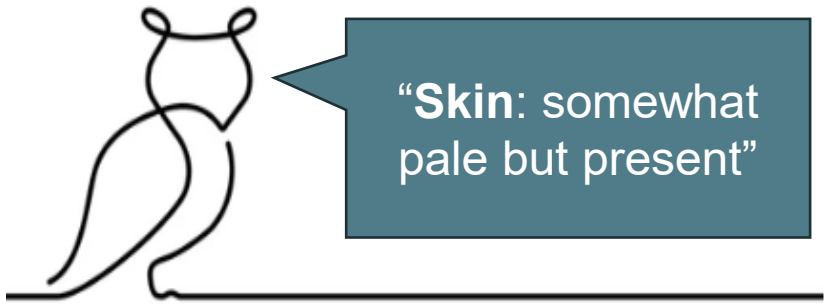
Plan:

- Wound Care
- Pain Control
- DVT Prophylaxis

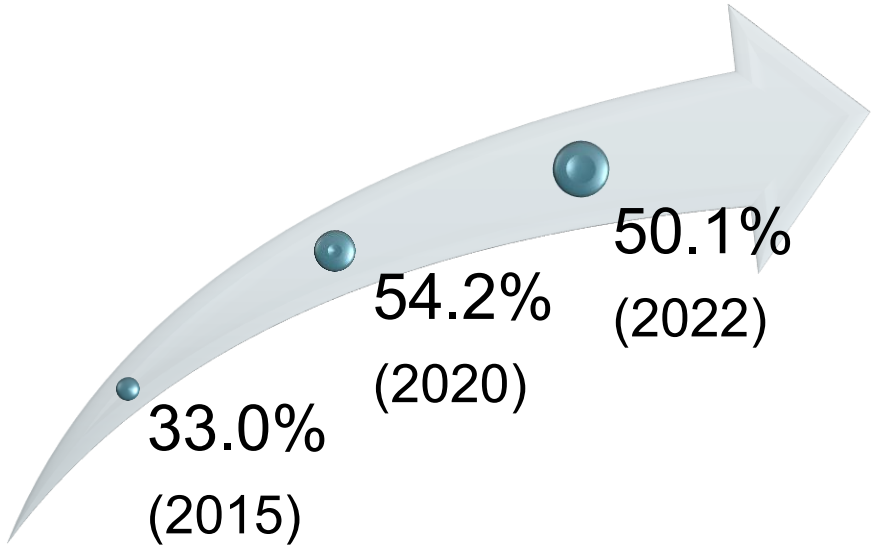
Copy/Paste

From WPS:

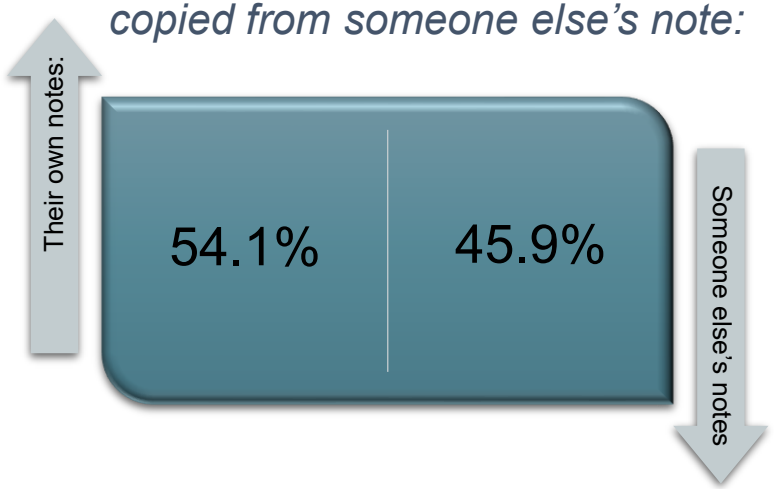
Using templates, checklists, or the "carry forward," "cut and paste," and "cloning" capabilities of your electronic health record system can be appropriate. The medical record, however, must be specific and complete for that patient for that date of service. The ***practitioner must document his/her review*** *of information*



Percentage of words duplicated from prior note:



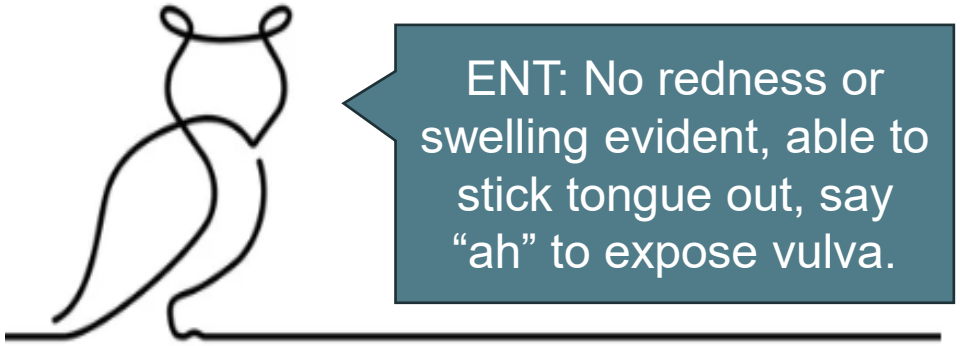
Of copied words, almost 46% were copied from someone else's note:



doi:10.1001/jamanetworkopen.2022.33348

How do we fix it?

- Step 1: Why is it being used?
- Step 2: Educate best practices.
- Step 3: Monitor, Assess, Re-educate!
- Step 4: Not working?
  Show them the consequences…

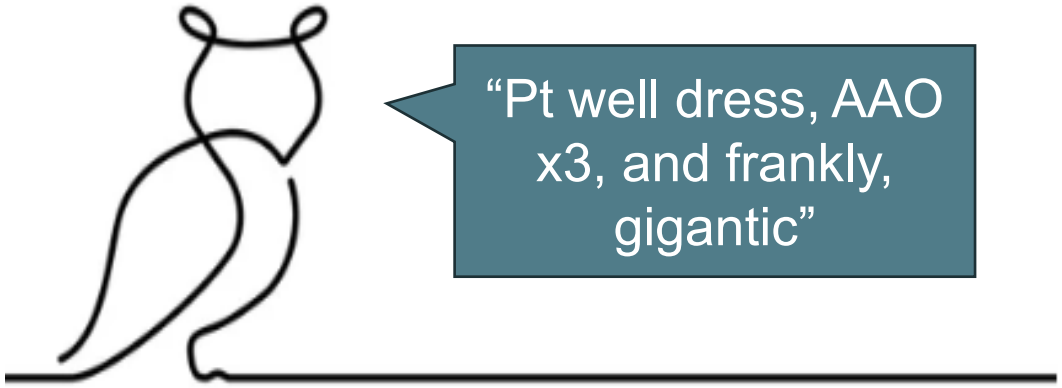


Cloning of Progress Notes, Upcoding Lead To Fraud Settlement; Doctors Pay $422,000

The cloning of electronic medical records has led to a fraud settlement, possibly for the first time.

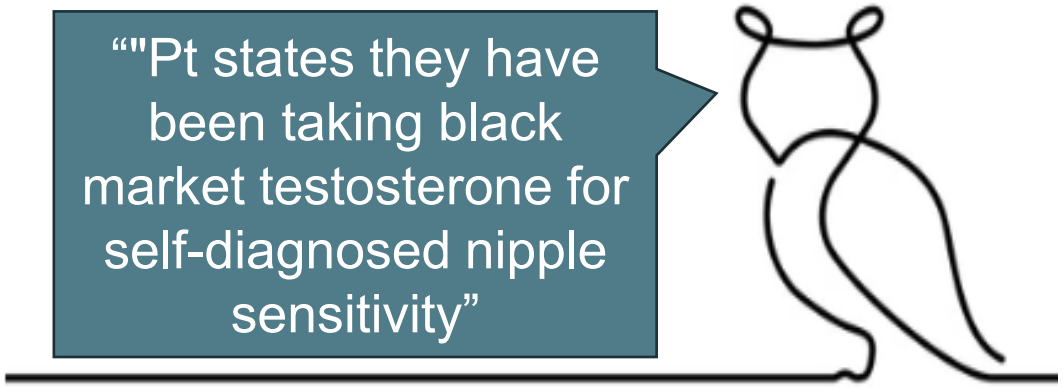
Somerset Cardiology Group, P.C., in Somerville, N.J., agreed to pay $422,741 in a civil money penalty (CMP) settlement stemming from allegations it submitted false or fraudulent claims. The six-physician cardiology group allegedly cloned patient progress notes and upcoded evaluation and management (E/M) services, according to the HHS Office of Inspector General (OIG). The settlement was the end result of the cardiology group's use of the OIG Self-Disclosure Protocol, which it entered in August 2015. Attorney Joseph Gorrell, who represents the cardiology group, tells *RMC* that it discovered the alleged billing errors through an internal quality assurance process. "Once identified, a self-audit was performed, followed by self-disclosure," says Gorrell, with Brach Eichler.

https://assets.hcca-info.org/Portals/0/PDFs/Resources/Rpt_Medicare/2016/rmc022216.pdf

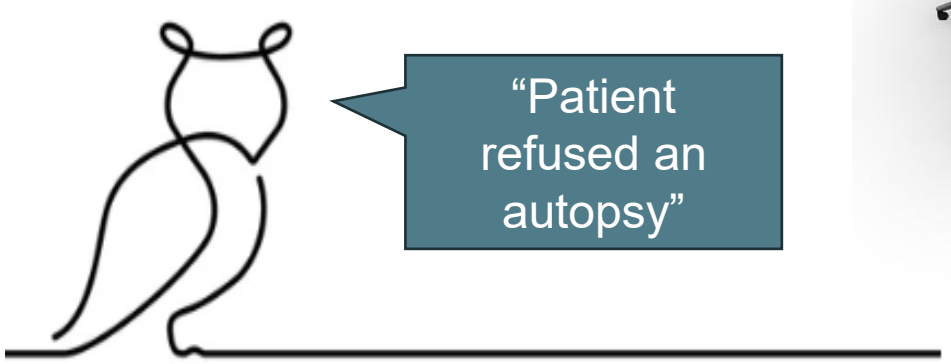


“Pt well dress, AAO x3, and frankly, gigantic”

“"Pt states they have been taking black market testosterone for self-diagnosed nipple sensitivity”



Delivering Education



Delivering Your Message

Education Goals:

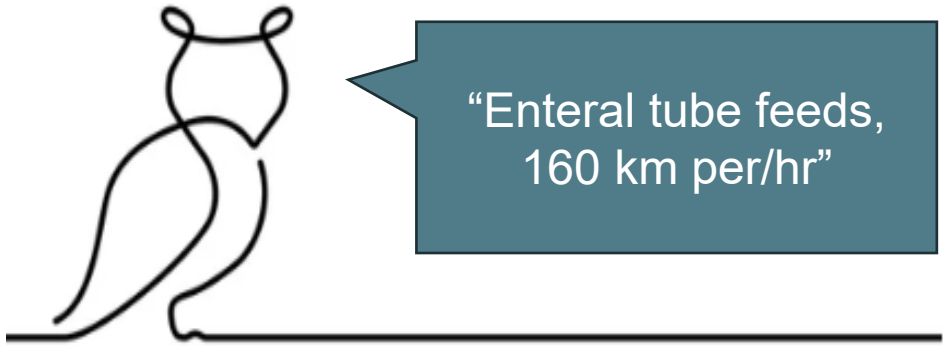
- Clarity
- Respect
- Realistic

How do you teach documentation without overwhelming?

How do you give feedback that's corrective but not confrontational?

How do you tailor training across different specialties and personalities?

Training Session Comments



By Trainer:

- They don’t listen… they just go on “autopilot”.
- They ask questions after I just explained the answer.
- They say they’ve always done it this way, so they aren’t changing.

By Provider

- They aren’t clinical (or a physician)
- They are caught up in guidelines and not patient care
- Boring/Unrelatable

It’s not what you say…

“You need to document better”

“You can’t say rule out”

“Don’t say ‘history of’ because that means…”

This isn’t coaching… it’s criticism!

“We’re looking for X, Y, and Z”

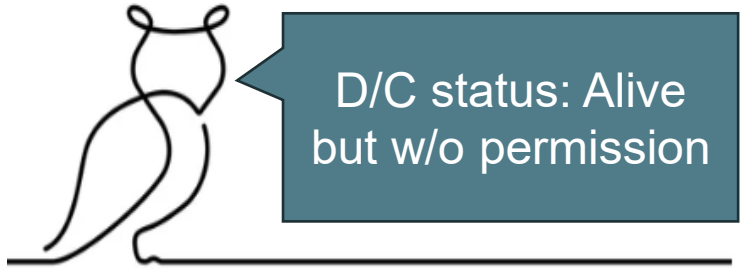
“Rule out conditions help determine MDM, but we can’t code them”

“I understand what you mean, but from a coding perspective, ‘history of’ means it no longer exists”

Know Your Audience

Physician Mindset	• Evidence-based information
Experience levels	• Newer = Foundation level • More Experience = Updates and Changes
Specialty	• Specialty-specific examples

Plan Your Session



Purpose

Root Causes

The Fix

Purpose for the Audit/Education

Why me? Why not them? What did I do?

Primary Cause of Errors

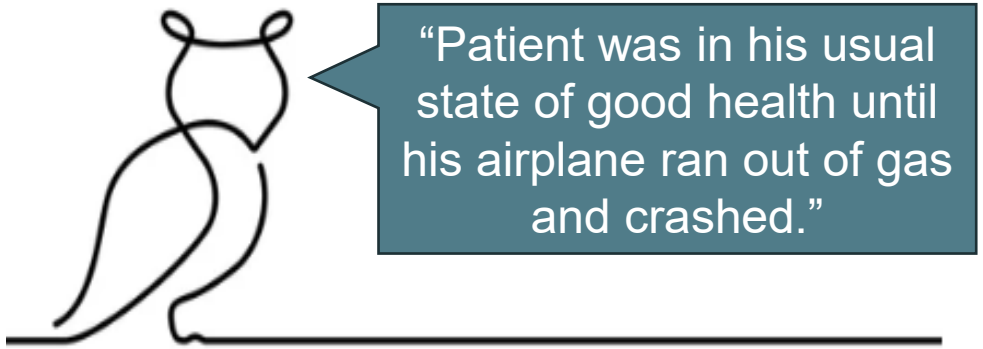
Templates? Copy/Paste? Vague Documentation?

Resolution: Prevent Future Errors

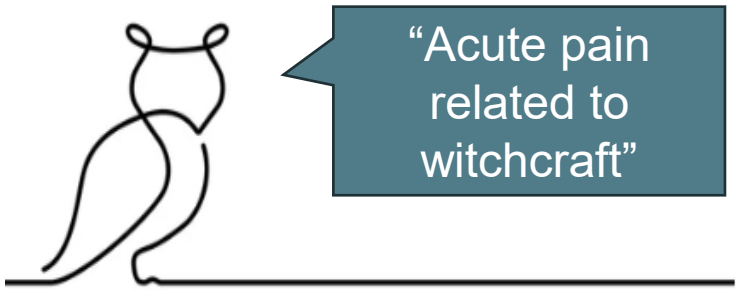
Template updates, smart phrases, IT/EMR training staff, experience colleague.

Handling Pushback

- Listen!
- “I see your point”, “I understand”
  - Let me send you the guidelines/policy and then we can revisit…
- Ask them to show you where in their note it explains risk, complexity, severity, etc…
- It’s okay to end a call!
  - I can see you’re upset. Let me end the call to give you some time to process the information and we can reschedule…



Final Tips & Takeaways



Microlearning

Be empathetic and sincere

Don’t read slides/script

Learn to read the room

Know their lingo and speak their language

Speak “low and slow”

Thank you!

Amanda Reikowsky, CMCPS, CPC, CRC, CPMA, CDEO

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www.codewisesolutionsllc.com

CodeWise SOLUTIONS

Post Event Survey!

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