Auditing and Monitoring Physician Services

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HCCA Compliance Institute
Auditing and Monitoring
Physician Services

Agenda

- Introduce today’s learning objectives
- Provide background on 2 organizations
  - Cleveland Clinic Foundation
  - Trinity Health
- Discuss each of the objectives and tools provided
- Question & Answer

Learning Objectives

- Determining Who, What, When and How to Conduct Monitoring and Auditing
- Developing Standards to Ensure Data Quality/Integrity
- Electronic Medical Records/Templates have on monitoring and auditing activities and their impact on auditing and monitoring
- Using Technology for Monitoring/Auditing and Reporting Processes
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The Cleveland Clinic

- 1,500+ multi-specialty group practice
- 1,043 bed academic medical center
- 100% employed physicians/providers
- 35+ specialty departments
- Locations in Cleveland, Ft. Lauderdale
  - Outpatient Visits: 2.8 million
  - Admissions: 52,004
  - Surgical cases: 96,700

Cleveland Clinic Foundation

- OI Program
  - Integrity Officer – Internal Audit and Compliance
  - Anticipate some re-structuring in 2006
- Current Organizational Structure
  - 10 Divisional Compliance Committees report to Corporate Compliance Committee
  - Departmental Monitoring/Auditing activities are performed by decentralized staff (standardized reporting to Compliance Committees)
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Cleveland Clinic Foundation (cont.)

- Professional Coding Department
  - Ten (10) coding staff
- Divisions of Medicine and Surgery
  - Two (2) E&M auditors plus designated reimbursement specialists
  - Surgical coders (100% OR procedures)
- Remaining Divisions
  - Designated reimbursement specialists and/or coding staff (multiple)

Trinity Health

- 4th largest Catholic health system in U.S.
- Operations in 7 states
- 45,000 FTEs and 7,300 physicians
- 44 hospitals, LTC, home health, hospice services
- 379 outpatient clinics/ facilities
  - (# of physician practices, # of providers)
- Trinity has 13 "Provider Sponsored Networks" consisting of approximately 380 providers in pediatrics, internal medicine, family practice and OB/GYN
Trinity Health- Organizational Integrity

- 13 FTEs with responsibility for OI Program management and auditing across The System
- ~4 FTEs with responsibility directly to provider services compliance
  - Employed providers/Owned physician practices
    - Physicians
    - Non-physician Practitioners
    - Provider Services Billing

HCCA Definition of Monitoring

- According to HCCA’s Seven Component Framework for Compliance Auditing and Monitoring in Healthcare Organizations:
  - Monitoring is a process involving ongoing “checking” and “measuring” to ensure quality control.
  - The process of monitoring is generally less structured than auditing and is typically performed by departmental staff.
  - Monitoring involves daily, weekly, or other periodic spot checks to verify that essential functions are being adequately performed and that processes are working effectively.
According to HCCA's Seven Component Framework for Compliance Auditing and Monitoring in Healthcare Organizations:

Auditing is a more systematic and structured approach to analyzing a control process [than monitoring]. It is a formal review (performed by an individual[s] independent of the department) that usually includes:

- Planning;
- Identifying risk areas;
- Assessing internal controls;
- Sampling of data;
- Testing of processes;
- Validating information; and
- Formally communicating recommendations and corrective actions to both management and the Board.

CCF Definition: Monitoring versus Auditing

- **Monitoring:**
  - Prospective/concurrent review of documentation, coding and billing processes by personnel in clinical/operational areas.
  - Credentialed staff that are operationally involved in the revenue cycle perform “audits” or “coding reviews” (i.e. division level or professional coding)
  - Quality of “monitoring” conducted as part of normal supervisory responsibilities
  - Benefits: Promotes up-front accuracy, immediate feedback and corrective action
  - Drawbacks: potentially less objective/independent
CCF Definition: Monitoring versus Auditing (cont.)

- **Auditing:**
  - Retrospective audit by Office of Compliance* or Internal Audit
  - Performed by external auditor and/or independent of area assessed.
  - More formal review
  - Benefits: independent, objective, comprehensive
  - Drawbacks: lack of resources, less timely feedback and corrective action.

Trinity Definition: Monitoring versus Auditing

- **Monitoring:**
  - Resources internal to area assessed
  - Performed on a regular, ongoing basis
  - May focus more on current and future activities
  - May be performed as part of ongoing QI/QA activity
  - Benefit: promotes ownership/responsibility/immediate feedback
  - Drawback: independence and objectivity, “glossing the surface”
Trinity Definition:
Monitoring versus Auditing (cont.)

- **Auditing:**
  - External or otherwise independent of area assessed
  - Performed periodically
  - May be retrospective, but not always
  - Benefit: independence and objectivity, more comprehensive
  - Drawback: lack of resources, more costly

- We believe an effective compliance program incorporates aspects of both auditing and monitoring

General Considerations:
Who, What, When & How

- **Who** should be the focus of your monitoring or auditing?
  - Define Audit Objective and Scope
    - All billing providers
    - Selected specialists
    - High volume providers
    - New programs

- **What** information or questions do you hope to answer with the monitoring or auditing activities?
  - Develop Audit Workplan and Timelines
    - All E/M Categories (IP, OP, Consult, etc.)
    - Establish a “base-line” or “snapshot”
    - Measure past trends
    - Test new regulations
    - Review new Providers
    - Conduct “focused” review of selected providers
    - Focus on a certain time period
    - Investigation
    - Following fieldwork, write draft report and obtain management response
    - Finalize report and follow-up
General Considerations: Who, What, When & How (cont)

❖ When does the auditing or monitoring need to be completed?
  • Within 1 year of employment or sooner
  • Determined by Annual Risk Assessment
  • Every 3 years
  • Follow-up audits

❖ How will the monitoring or auditing be performed?
  - Establish the review or audit methodology upfront
  - Retrospective versus Prospective
  - Determine the sample selection process
    • Random
    • Probe
    • Statistically Valid (e.g. RAT-STATS)
  - What criteria will be applied (e.g. 1995 or 1997 E&M Guidelines)?
  - Determine what regulations will be applied (e.g. Medicare, Medicaid, Payer-specific)

CCF: Define Who, What, When, & How

Determining Who, What, When and How

❖ Compliance Committee establishes minimum “monitoring/audit” requirements to be performed by each division
  • Credentialed reimbursement/coding staff employed by departments and/or divisions perform “audits”
  • Quarterly reporting to Division Compliance Committees
  • Annual reporting by Division to Corporate Compliance Committee

❖ Compliance and Internal Audit coordinate or perform retrospective audits that result from:
  • Issues identified during monitoring, hotline complaints, etc
  • Risks based on OIG workplan, other identified risks
CCF: Define Who, What, When, & How (cont.)

- **Who** should be the focus of your monitoring or auditing?
  - All providers who code and bill for services rendered are audited
  - All "coders" who code services for providers are audited for quality

- **What** information or questions do you hope to answer with the monitoring or auditing activities?
  - New Providers – Baseline audit
  - Annual audit - All E&M "categories" (weighted according to physician billing practices)

- **When** does the auditing or monitoring need to be completed?
  - Initial month of E&M services rendered (new)
  - Pattern of E&M outliers and/or every 12 – 18 months from last audit

- **How** will the monitoring or auditing be performed?

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Trinity: Define Who, What, When, & How

- **Who** should be the focus of your monitoring or auditing?
  - All providers who bill for services rendered get audited

- **What** information or questions do you hope to answer with the monitoring or auditing activities?
  - New Programs
  - All E&M "categories"
  - IP, ER, Office, etc.

- **When** does the auditing or monitoring need to be completed?
  - Within 1 year of employment
  - Determined by Annual Risk Assessment
  - Every 3 years

- **How** will the monitoring or auditing be performed?
General Considerations: Develop Standards to Ensure Data Quality & Integrity

- Data sources and input
  - Internal data
  - External/industry data for monitoring/benchmarking (AAMC, OIG Modifier 25 [see detail, next slide])

Using External Data Sources
- CMS Physician/Supplier National Part B Extract Summary System (BESS) Data
  - Provides "raw" data by Medicare Specialty Designation (e.g. Dermatology 07, Cardiology 06, etc.)
  - Illustrates CY allowed charges/allowed payments and utilization by CPT code
- Carrier Specific Reports
- OIG Reports/Alerts
- MGMA 2004 Coding Profile Sourcebook (Physcape)
  - Surgical Specialties, Pathology & Radiology
  - Medical Specialties
  - Primary Care Specialties
- Other sources

Data Sources: HGSA – ULTRA Report

Data Sources: Humana High-Intensity Claims Review

High-intensity Claims Review Process
Humana is prospectively screening high-intensity evaluation and management (E/M) claims for any and suspicious outlier payment amounts and referring those claims for further (appropriate).

Following is a summary of steps our process for reviewing high-intensity E/M claims is:

- Identify claims from physicians whose high-intensity E/M claims coding practices are above the top 1% percentiles for similar codes and providers.
- Review claims to ensure appropriate coded based on services provided and documented.
- Suspend inappropriate payments and refer for further review.

We will be reviewing for a category of outlier coding, which are over 100% of the median.

Data Sources: Analyze Carrier Probe Information

Medicare Services

Provider Information

Managed Priority Probe Planned for Initial Hospital Evaluation and Management Services in OK
Published Date: 11/22/2005

Provider Name: Oklahoma City VA Health Care System

Initial Hospital Evaluation and Management services accounted for 9% of the total USF and 6% of the total Medicare universe. As the total service was a high revenue service, the high DODS were due to a few high revenue claims.

The 50 highest outlier claims were reviewed on 100% basis and will be referred to the Medicare Review for further review. If the high outlier claims are determined to be accurate, the provider will be notified.

If an Additional Diagnostic Brought (ADIS) is reviewed, the provider must submit the appropriate medical record documentation to support the coding. If the coding is supported, the provider will be notified.

For any claims that are referred, the 3DRS will identify the claims to be included in the probe sample. Please submit the requested information within 30 days of receipt of the 3DRS.

Data Sources: Use Carrier Service Specific Probe Information

Source: http://www.oknmmedicare.com/provider/mr/probereview.asp

Data Sources: WPS Probe Findings

- Michigan: Overall error rate for CPT code (99213) 22.10%
  - Requested records not received: 18.15%
  - Documentation does not support services billed: 1.04%
  - Services not billed under appropriate procedure code: 1.04%
  - Service not documented in medical record: 0.98%
  - Documentation supports a lower level of care than service billed: 0.88%

- Minnesota: Overall error rate for CPT code (99232) 51.39%
  - Requested records not received: 34.95%
  - Services not documented in record: 14.06%
  - Documentation supports a lower level of care than services billed: 2.38%

Source: http://www.wpsic.com/medicare/provider/pdfs/emwkbk.pdf (Pages 69 thru 76)
Data Sources: CERT Report Findings

Includes the Top 20 CMS Upcoding Errors - Carriers

*Note: Of the 20, the Top 5 were E/M services*

<table>
<thead>
<tr>
<th>Service Billed to Carrier</th>
<th>Paid Claims Error Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial inpatient consult (99255)</td>
<td>19.7%</td>
</tr>
<tr>
<td>Office/outpatient visit, est (99215)</td>
<td>18.6%</td>
</tr>
<tr>
<td>Office/outpatient visit, new (99204)</td>
<td>18.5%</td>
</tr>
<tr>
<td>Office consultation (99245)</td>
<td>17.5%</td>
</tr>
<tr>
<td>Office/outpatient visit, new (99205)</td>
<td>15.5%</td>
</tr>
<tr>
<td>Nursing facility care (99303)</td>
<td>15.2%</td>
</tr>
</tbody>
</table>

*Source: Improper Medicare Fee-for-Service Payments Report FY 2004, Supplementary Appendices*

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Data Sources: Physician’s Practice E/M Calculator

*Source: http://www.physicianspractice.com/tools/em_calc.html*
OIG Reports - Modifier 25

- Medicare allowed $538 million in improper payments in 2002 for services billed with modifier 25
  - Study identified that 28% of all providers in the sample population used modifier 25 on more than 50% of their claims
- Modifier 25 should only be used with the E/M service portion of a Medicare claim and not on the procedure portion of the claim
- If used properly for every encounter, modifier 25 should be used no MORE than 50% of services billed

Source: DHHS OIG Use of Modifier 25, November 2005

General Considerations:
Develop Standards to Ensure Data Quality & Integrity (cont.)

- Validating data sources and input
  - Clinical versus billing system data
    - Clinical system data or charge tickets may be incomplete (missing charges)
    - Clinical system data or charge tickets may not include final billed codes (due to “behind the scenes” conversion tables/crosswalks)
    - May not reflect what was ultimately billed
  - Billing System data
    - Need to know if “claims scrubber” used (may edit for CCI, other)
    - Need to know what “corrections” may be made manually by billing staff (after claims have been through the scrubber)
    - May not reflect what was ultimately billed/paid
  - Carrier data
    - Reflects what was actually billed/paid
    - Challenge: retrospective review versus prospective
General Considerations:
Develop Standards to Ensure Data Quality & Integrity (cont.)

- Standards for Conducting Audits
  - Attorney-client privilege
    - Protocols and privilege
  - Auditor Productivity standards
    - Allocating resources appropriately

- Standards for Documentation
  - Workpapers
  - Retention
  - IA and Sarbanes 404 standards/impact

- Standards for Communication
  - Formal audit plan
  - Entrance/exit conference
  - Verbal findings versus written reports

General Considerations:
Develop Standards to Ensure Data Quality & Integrity (cont.)

- Standards for Interpreting Results
  - Defining accuracy thresholds
    - Achieve 100, 95 or 90% accuracy
    - What’s included in determining the accuracy count?
      - E/M only
      - All CPT codes
      - ICD-9-CM codes
      - Modifiers
      - Teaching Physician
  - What is a “finding” or “error” and how is it reported?
    - Weighted scale (e.g., point system/score card)
  - One level E/M code differences
General Considerations: What is an “Error”

- AAMC on E/M Audit Survey Results
  - Total # 36 respondents
  - Total # 13 questions (addressed review methodologies, educational approaches and solicited suggestions and tips for success)
  - Fixed passing rates vary 70-95%
  - Majority review presence statements (approximately 97%)

Source: AAMC E/M Audit Survey Results Dec. 2003

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General Considerations: AAMC E/M Survey Results

<table>
<thead>
<tr>
<th>Total# Responses</th>
<th>Question #2</th>
<th>Responses</th>
</tr>
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<tbody>
<tr>
<td>32</td>
<td>Is undercoding by one level considered to be an “error”?</td>
<td>Yes 22</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(89%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No 10</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(31%)</td>
</tr>
</tbody>
</table>

Total # of Respondents: 36
Note: Not every respondent answered every question

Source: AAMC E/M Audit Survey Results Dec. 2003
### General Considerations: AAMC E/M Survey Results (cont.)

#### Question #3

<table>
<thead>
<tr>
<th>Total Responses</th>
<th>Question #3</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>29</td>
<td>Is undercoding by more than one level considered to be an “error”?</td>
<td>Yes 24 (83%)</td>
</tr>
</tbody>
</table>

Total # of Respondents: 36  
Note: Not every respondent answered every question

Source: AAMC E/M Audit Survey Results Dec. 2003

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### General Considerations: AAMC E/M Survey Results (cont.)

#### Question #4

<table>
<thead>
<tr>
<th>Total Responses</th>
<th>Question #4</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>35</td>
<td>Is overcoding by one level considered to be an “error”?</td>
<td>Yes 27 (77%)</td>
</tr>
</tbody>
</table>

Total # of Respondents: 36  
Note: Not every respondent answered every question

Source: AAMC E/M Audit Survey Results Dec. 2003
### General Considerations: AAMC E/M Survey Results (cont.)

<table>
<thead>
<tr>
<th>Total Responses</th>
<th>Question #6</th>
<th>Responses</th>
</tr>
</thead>
</table>
| 30              | Do you review all services for all payers or just services for Medicare?    | Yes 20  
                  |                                | (67%) No 10  
                  |                                | Medicare Only (33%)          |

Total # of Respondents: 36  
Note: Not every respondent answered every question

Source: AAMC E/M Audit Survey Results Dec. 2003

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| Total Responses | Question #10                                                              | Prospectively 10  
                  | (29%) Retrospectively 17  
                  | (50%) Both 7  
                  | (21%) |
|-----------------|---------------------------------------------------------------------------|----------------------|
| 34              | Do you conduct reviews prospectively or retrospectively?                   |                      |

Total # of Respondents: 36  
Note: Not every respondent answered every question

Source: AAMC E/M Audit Survey Results Dec. 2003
General Considerations: Sample Coding Scorecard

Coding Scorecard

Each medical record is reviewed and scored according to a point system. The audit score is the cumulative score for all audit points. A program with an audit score of 11 or more points is considered non-compliant. Five or more encounters are audited during any audit period; the audit score shall be calculated based on the following formula:

\[
\text{Audit Score} = \sum_{i=1}^{n} \text{Points} = \text{Audit Score} \times \text{Number of Encounters Audited}
\]

Following are the coding descriptions and their respective point values:

<table>
<thead>
<tr>
<th>Description</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Documentation meets all requirements</td>
<td>6</td>
</tr>
<tr>
<td>Record not sufficiently legible to support billing</td>
<td>1</td>
</tr>
<tr>
<td>Incorrect code used: incorrect category of service</td>
<td>2</td>
</tr>
<tr>
<td>Incorrect service: incorrect service code</td>
<td>2</td>
</tr>
<tr>
<td>Incorrect service: incorrect time period</td>
<td>3</td>
</tr>
<tr>
<td>Improper use of modifier</td>
<td>3</td>
</tr>
<tr>
<td>Unassigned or non-CPT coded</td>
<td>4</td>
</tr>
<tr>
<td>Incorrect documentation of patient presence</td>
<td>10</td>
</tr>
<tr>
<td>Documented or insufficient documentation of service provided</td>
<td>10</td>
</tr>
</tbody>
</table>

CCF: Develop Standards to Ensure Data Quality & Integrity

- **How to handle individual coding variances?**
  - Corrected/Final code must be submitted (pre-billing audit) or refunded (retrospective audit)

- **Interpreting Audit Results**
  - Establish standard (threshold)
    - 100% agree or within 1 level of same category E&M service
  - Threshold for further review or corrective action
    - Meet standard: re-audit in 12-18 months
    - Do not meet standard: educate, re-audit within 30 days.
    - Do not meet standard again: Focused, ongoing coding verification prior to billing.
How to report findings?
- Monitoring Activities Summary Report
- Written summary and recommendations
- Working to make method of feedback more consistent

How to apply Productivity Standards?
- # of charts audited / hour – What is included (chart audit? feedback? report writing?)

Who performs reviews/audits?
- Credentialed coding staff with appropriate supervision
- Who is auditing the auditors?

How are they conducted?
- To use or not to use Attorney-Client privilege
- Interpretation of “grey” areas
  - Carrier guidance per educational sessions
  - Internal “consensus” by coding staff/managers
- Prospective or retrospective; random or focused sample
Trinity: Develop Standards to Ensure Data Quality & Integrity

Who performs reviews/audits?
- Credentialed "professional services" coders CPC, CCS-P, Advanced Practice

How are they conducted?
- Concurrent, retrospective, attorney-client privilege
- Audit Standards are developed for consistency where guidelines are grey

How to report findings?
- Formal reporting structure with management responses required

How to apply Productivity Standards?
- Yearly budgeting based on # of providers audited across whole process (planning, fieldwork, report writing, etc.)
- Validate with external consultants
Methods Used to Report Audit Results

- **Narrative**
- **Spreadsheet**
- **Charts & Graphs**
- **Verbal**

Verbal Reporting

- **Preliminary Reports**
- **Emergency Reports**
  - Serious non-compliant finding
    - Allows immediate stoppage of billing until fixed
    - Allows you to consult counsel
    - Might reveal a ‘flaw’ in the audit process
- **Individualized provider report with training**
- **Group report to providers**
  - In-service training
- **Compliance report to board of directors or other entity**
  - Demonstrate compliance program’s effectiveness
- **Plans for next steps for improved compliance**
**HCCA Compliance Institute**

**Auditing and Monitoring Physician Services**

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### Using Technology in Monitoring/Auditing Process

- Packaged Software Solutions/Tools
  - Intellicode™
  - MDAudit™
- Home-grown monitoring/auditing tools
- Web-based tools
- Access databases
- Excel spreadsheets
- Other (word templates, Microsoft Powerpoints, etc.)

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### Graphs & Charts

#### Evaluation and Management Code Distribution

![Bar Chart Image]

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## Other Considerations – Electronic Medical Record

- Auditing EMR creates new challenges
- Integrity of the record
  - Controls around access
  - Who documented what?
  - Signatures/authentication
  - Cut/copy/paste features
  - Cloning (defaulted documentation)
  - Macro’s
  - How clinical documentation is “filed” within the EMR (understanding the protocols)
- Identifying consultation requests/written reports
- Determining appropriate E/M code category
  - New, Established, Consult or Preventive Medicine
- Documentation of drugs, supplies and equipment

## Other Considerations: Electronic Medical Record (cont.)

- Anticipating impact EMR will have on standards
  - Process to conduct the audits may change
  - How and where audits are conducted
  - Accessibility to pertinent source documents
  - Ability to conduct prospective versus retrospective
  - Tracking results
- New subjective auditing areas may emerge
  - Templates contained within EMR may not be compliant
  - Presence and participation by Teaching Physicians may be difficult to validate
  - Other issues such as quality of care issues may emerge
Other Considerations: NHIC Precautions Regarding Using EMR

- Physician practices need to keep in mind the following:
  - Does the documentation support that a service was rendered?
  - Does the record provide **individualized** documentation relevant to that patient on that date of service?
  - Will the documentation adequately support the medical necessity for a particular service to a third party reviewer?

- The medical record for each date of service should reflect **individualized** documentation relevant to the medical necessity of the service/procedure rendered and/or patient care provided on that date of service.


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Other Considerations: NHIC Precautions Regarding Using EMR (cont.)

- The recommendations listed below are provided to assist physicians/non-physician practitioners with recordkeeping practices:
  - The patient’s chief complaint and the purpose of the visit;
  - The medical necessity for the service should be validated in the documentation;
  - An examination pertinent to the patient’s medical condition; and
  - Individualized treatment rendered or ordered for each date of service.

### Other Considerations: Documentation Templates

#### Pros
- Streamline documentation capture process for providers
- Provide standardized information
- Improve legibility
- Aid in continuity and quality of patient care
- Assist providers in recalling the documentation requirements
- Easier to audit and provide feedback

#### Cons
- Limit providers ability to free text information
- May promote documenting more than what was rendered
- Can lead to “canned” or “cloned” documentation
- May be used inappropriately or misinterpreted by the user
- May promote non-compliant short-cuts
- May turn medical record progress notes into audit worksheets

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#### Other Considerations: Documentation Templates (cont.)

- NHIC indicates that providers can utilize documentation templates as they can streamline the process and ensure consistency of medical facts, services and information
  - Suggest customizing templates according to specific services rendered by a physician specialty or practice
- NHIC cannot approve or endorse templates created as the template itself does not qualify as a covered service.
  - The quality and content information documented within the template must describe and support the service reports for Medicare reimbursement.

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Source: NHIC, Medical Review Updates - NHIC Message from Medical Review - September 2003, pg. 67.
Other Considerations: Computerized Documentation

- Carrier Probe Review Findings
  - One of the probe reviews found several physicians whose office records indicated they use a computerized documentation program that “defaults” information from previous entries to successive progress notes.
  - It was noted that some physical examinations were nearly identical on subsequent visits, even when there was a change in diagnosis(es).

Source: Trailblazer Medicare Sentinel No. 02-2S, Sept. 30, 2002

- In addition, multiple patients had the exact same findings upon follow-up visits.
  - Medicare is concerned that defaulted documentation may cause a provider to overlook significant new findings.
  - Medicare is also concerned that the provider’s computerized documentation program defaults to a more extensive history and physical examination than is medically necessary to perform on a given day, and does not differentiate new findings and changes in a patient’s condition.

Source: Trailblazer Medicare Sentinel No. 02-2S, Sept. 30, 2002
Other Considerations:  
Computerized Documentation (cont.)

- If providers and their staff want to document electronically, they must ensure that the documentation accurately reflects the level of history, examination, and medical decision-making performed on a given day, and not information defaulted from a previous entry.

- Medicare only reimburses services according to the medical necessity of the patient’s condition on a specific date of service.

Source: Trailblazer Medicare Sentinel No. 02-2S, Sept. 30, 2002

Other Considerations:  
CMS Teaching Physician (TP) Regulations

- Documentation may dictated and typed or handwritten or computer-generated and typed or handwritten.
- Documentation must be dated and include a legible signature or identify.
  - 42 CFR, 415.72 (b) documentation must identify at a minimum the:
    - Service furnished
    - Participation of the TP in providing the service
    - TP’s physically presence
  - With EMR it is acceptable for the TP to use a “macro” as the required personal documentation if TP adds it personally in a secured (password protected) system.

Other Considerations: CMS Teaching Physician (TP) Regulations (cont.)

- In addition to the TP’s macro, the resident or TP must provide customized information that is sufficient to support a medical necessity determination.
- EMR note must sufficiently describe the specific services furnished to the specific patient on the specific date.
- It is insufficient documentation if both the resident and the TP use macro’s only.
  - Physically present: TP must be located in the same room (or partitioned/curtained area, if the room is subdivided to accommodate multiple patients) as the patient and/or performs a face-to-face service.


Other Considerations: Volume of Documentation vs. Medical Necessity

- During repeated reviews we have observed the tendency to “over document” and consequently select a higher level E/M than medically reasonable and necessary.
- Word processing software, the electronic medical record and formatted note systems facilitate the “carry over” and repetitive “fill-in” of stored information.
- Even if a complete note is generated only the reasonable and medically necessary services for the condition of the particular patient at the time of the encounter as documented can be considered when selecting the appropriate level of E/M service.
- Information that has no pertinence to the patients at that specific time cannot be counted.

Source: Cigna (A19687) North Carolina 6/3/04: Medicare Coverage Database
Discussion

- What challenges are you seeing?
- What have you learned?
  - Best Practices?

Questions/Answers

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