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High Risk Areas in Documentation & Coding

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Areas of High Risk

- Modifier -25
- Chief complaint
- Medical necessity
- Copy and Paste/Templates
- Time-based E/M
- Hospital discharge days

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Separately Identifiable E/M

- Defined as “Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service.”
- Modifier -25 is applied to the E/M
 - Preventive visits with an E/M
 - Outside of the usual preventive service
 - Documentation for E/M must be “carved out”
 - Must have documentation supporting the E/M that is not part of the usual preventive service
 - Minor procedures with an E/M
 - Intent of the visit

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Chief Complaint

- Required for all evaluation and management (E/M) services
- Hospital subsequent care and nursing home visits are a big focus
 - Rounding for “administrative” purposes is considered a social visit
- Absence of chief complaint deems a service non-billable

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Medical Necessity

- Medical necessity is now a focus in the professional side
- Focus on “note bloat”
 - Performing comprehensive histories and exams on all patients
 - Is it medically necessary to perform a gastrointestinal and respiratory exam on an otherwise healthy patient with a broken arm?
 - Medical decision making is becoming a driver
- EMRs
 - Using templates
 - Copying and pasting
 - Pulling forward information that is not reviewed
- Compromise documentation integrity
 - Contradictory documentation
 - Other patients information from copy & paste
 - A surgery that was performed yesterday, for 5 straight days
 - A patient complaining of nausea and vomiting that has a negative GI system review

Copy/Paste and Templates

Cloning—This practice involves copying and pasting previously recorded information from a prior note into a new note, and it is a problem in health care institutions that is not broadly addressed.[16, 17] For example, features like auto-fill and auto-prompts can facilitate and improve provider documentation, but they can also be misused.

The medical record must contain documentation showing the differences and the needs of the patient for each visit or encounter. Simply changing the date on the EHR without reflecting what occurred during the actual visit is not acceptable. Using electronic signatures or a personal identification number may help deter some of the possible fraud, waste, and abuse that can occur with increased use of EHRs.[18] In its 2013 work plan, the U.S. Department of Health and Human Services, Office of Inspector General (HHS-OIG) indicated that due to the growing problem of cloning, its staff would be paying close attention to EHR cloning.[19, 20]

<https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/docmatters-ehr-providerfactsheet.pdf>

Time-Based E/M

- For visits that counseling and coordination of care dominate the service
 - Must be greater than 50%
 - Documentation supporting the discussion
- Time is being checked
 - Patient check-in and check-out times
 - Hours in a day
 - Audit trails in the EMR

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Hospital Discharge Days

- Hospital discharge day management
 - 99238
 - No time documented
 - 30 minutes or less documented
 - 99239
 - More than 30 minutes of time documented
- Additional requirements, as appropriate
 - Final examination of the patient
 - Discussion of the hospital stay
 - Discharge instructions
 - Preparation of discharge records, prescriptions, and referrals

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Questions

FOR MORE INFORMATION, PLEASE CONTACT:

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