Reimbursement Policy and Medical Records Documentation

Presented by:
Kimberly Haas, CPC
Clinical Policy & Reimbursement Analyst
Moda Health Plan

Friday, February 5, 2021, 11:00 – 12:00 noon
Health Care Compliance Association (HCCA)
Portland Regional Healthcare Compliance Virtual Conference

1

Learning Objectives

* Identify appropriate documentation which can be used to support billed services.
* Define the correct way to make legal additions or corrections to the medical record.
* Identify common documentation problems that lead to denials and how to avoid them.

2

Learning Objective # 1

Identify appropriate documentation which can be used to support billed services.

3

Documentation to Support Billed Services

Documentation may need to be submitted to support billed procedure codes when:

* The health plan requests records for review during adjudication.
* A procedure code was denied with a bundling edit and you are submitting an appeal because you believe the service is eligible for separate reimbursement.
* Your office receives a records request from a Medicare Recovery Audit Contractor (RAC) or Certified Error Rate Testing (CERT) auditor.

4

Question for Participants:

What are some other situations when your office may need to submit documentation to support billed procedure codes?

5

Coding verification to support reimbursement of billed procedure codes:

Supporting documentation for all billed services must be contained in the patient's written medical record.

6

Legal standard:

If it's not documented,
it wasn't done.

7

Participant Survey Question:

Regarding the statement:

"If it's not documented, it wasn't done":

A. I am very familiar with this statement, and we consistently follow it at our office/company in our documentation and billing practices.
B. I am very familiar with this statement, but at my office/company we could do better in following it in our documentation and billing practices.
C. I have heard this statement before, but don't think of it often.
D. I have never heard this statement before.

8

Effect on business revenue:

If it's not documented, it's not done.

If it's not done, it cannot be billed.

If it's billed and it's not documented, then it's not done, and no reimbursement can be given.

9

Items which are part of the medical record:

* Physician orders
* Visit notes
* Operative report
* Written interpretation and report:
  * Sleep study
  * X-ray, MRI, CT scan, ultrasound, etc.
  * EKG
* Medication administration and/or infusion records
* Nurses notes
* Physical therapy visit notes

10

Items NOT considered part of the medical record: Part 1

* Notations (typed or handwritten) on:
  - Claim.
  - Fax cover sheet.
  - Copy of the records request letter.
* Statements during phone conversations discussing the claim.
* Statements in emails.
* Appeal letters and/or reconsideration requests.

11

Items NOT considered part of the medical record: Part 1, comments

All notations or statements in these locations or documents are useful to:

* Explain the coding, such as why specific procedure code or modifier (e.g., 52 or 22) was used.
* To call the reviewer's attention to what happened and/or what information to look for within the medical record.

The documentation within the medical record itself must agree with and support these statements and notations in order to support the billed procedure codes and reimbursement for them.

12

Items NOT considered part of the medical record: Part 2

* Appointment books, schedules, ledgers, logs (electronic or handwritten)
  - These items show what was planned or scheduled, but not what actually happened during patient care.
  - These items are not part of the patient's medical record. They are part of the provider's business documentation.

13

Items NOT considered part of the medical record: Part 3

* Charge logs, supply logs, pharmacy logs, sheets of supply stickers, etc.
  - These items show what was checked out for the patient or taken to the patient's exam room or care area. They do not document that the item was used during care of the patient.
    - Unused supplies are not billable.
    - Items opened and dropped/contaminated are not billable.
  - These items are not part of the patient's medical record. They are part of the provider's business documentation.

14

The medical record documentation must contain appropriate and sufficient information to clearly show:

* All the elements of the procedure code description were fully performed.
* The requirements for separate reimbursement from other billed procedure codes have been performed and/or met.

15

Example: Elements of Procedure Code Description

63081 = Vertebral corpectomy (vertebral body resection), partial or complete, anterior approach with decompression of spinal cord and/or nerve root(s); cervical, single segment

Elements that must be documented:

* Which vertebral segment was involved? (Required: cervical)
* Amount of the vertebral body resected. (Either partial or complete is acceptable).
* The surgical approach used. (Required: anterior)
* That the spinal cord and/or nerve root was decompressed.

16

Example: Requirements for separate reimbursement

Source:

CMS. *National Correct Coding Initiative Policy Manual*. Chapter 4 Surgery: Musculoskeletal System, § E, "Arthroscopy," subsection 4

"With 3 exceptions (which are described in Chapter IV, Section E (Arthroscopy), Subsection 7), an NCCI PTP edit code pair consisting of 2 codes describing 2 shoulder arthroscopy procedures shall not be bypassed with an NCCI PTP-associated modifier when the 2 procedures are performed on the ipsilateral shoulder. This type of edit may be bypassed with an NCCI PTP-associated modifier only if the 2 procedures are performed on contralateral shoulders. "

17

14 Possible Shoulder Arthroscopy Procedure Codes

	A	B	C	D	E	F
1	Code	Code Service Description	CodeYe	CodeTy	CodeStat	Effectiv
2269	29805	Arthroscopy, shoulder, diagnostic, with or without synovial biopsy (separate procedure)	2021	CPT	C	1/1/2021
2270	29806	Arthroscopy, shoulder, surgical; capsulorrhaphy	2021	CPT	C	1/1/2021
2271	29807	Arthroscopy, shoulder, surgical; repair of SLAP lesion	2021	CPT	C	1/1/2021
2272	29819	Arthroscopy, shoulder, surgical; with removal of loose body or foreign body	2021	CPT	C	1/1/2021
2273	29820	Arthroscopy, shoulder, surgical; synovectomy, partial	2021	CPT	C	1/1/2021
2274	29821	Arthroscopy, shoulder, surgical; synovectomy, complete	2021	CPT	C	1/1/2021
2275	29822	Arthroscopy, shoulder, surgical; debridement, limited, 1 or 2 discrete structures (eg, humeral bone, humeral articular cartilage, glenoid bone, glenoid articular cartilage, biceps tendon, biceps anchor complex, labrum, articular capsule, articular side of the rotator cuff, bursal side of the rotator cuff, subacromial bursa, foreign body[ies])	2021	CPT	C	1/1/2021
2276	29823	Arthroscopy, shoulder, surgical; debridement, extensive, 3 or more discrete structures (eg, humeral bone, humeral articular cartilage, glenoid bone, glenoid articular cartilage, biceps tendon, biceps anchor complex, labrum, articular capsule, articular side of the rotator cuff, bursal side of the rotator cuff, subacromial bursa, foreign body[ies])	2021	CPT	C	1/1/2021
2277	29824	Arthroscopy, shoulder, surgical; distal claviculectomy including distal articular surface (Mumford procedure)	2021	CPT	C	1/1/2021
2278	29825	Arthroscopy, shoulder, surgical; with lysis and resection of adhesions, with or without manipulation	2021	CPT	C	1/1/2021
2279	29826	Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (ie, arch) release, when performed (List separately in addition to code for primary procedure)	2021	CPT	C	1/1/2021
2280	29827	Arthroscopy, shoulder, surgical; with rotator cuff repair	2021	CPT	C	1/1/2021
2281	29828	Arthroscopy, shoulder, surgical; biceps tenodesis	2021	CPT	C	1/1/2021
16134	S2300	Arthroscopy, shoulder, surgical; with thermally-induced capsulorrhaphy	2021	HCPCS		1/1/2021
16790						

CPT + HCPCS combined | CPT only | HCPCS only | ICD 10-CM Dx

14 of 16788 records found

18

How many possible combinations of 2 shoulder arthroscopy procedures?

14 shoulder arthroscopy procedure codes

X

(multiplied by)

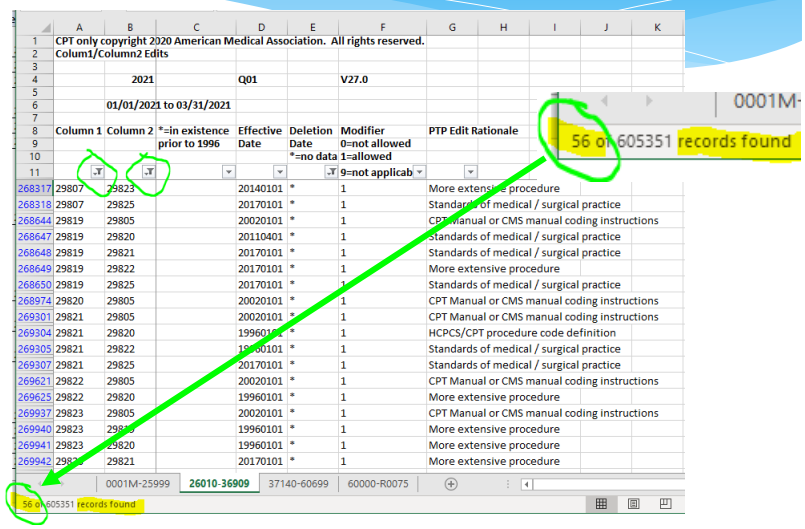
14 shoulder arthroscopy procedure codes

=

196 possible combinations of
two shoulder arthroscopy procedure codes

19

How many CCI PTP edits for combinations of 2 shoulder arthroscopy procedures?



	A	B	C	D	E	F	G
1	CPT only copyright 2020 American Medical Association. All rights reserved.						
2	Colum1/Column2 Edits						
3							
4		2021		Q01		V27.0	
5							
6		01/01/2021 to 03/31/2021					
7							
8	Column 1	Column 2	*=in existence prior to 1996	Effective Date	Deletion Date *=no data	Modifier 0=not allowed 1=allowed	PTP Edit Rationale
9							
10							
11						9=not applicab	
268317	29807	29823		20140101	*	1	More extensive procedure
268318	29807	29825		20170101	*	1	Standards of medical / surgical practice
268644	29819	29805		20020101	*	1	CPT Manual or CMS manual coding instructions
268647	29819	29820		20110401	*	1	Standards of medical / surgical practice
268648	29819	29821		20170101	*	1	Standards of medical / surgical practice
268649	29819	29822		20170101	*	1	More extensive procedure
268650	29819	29825		20170101	*	1	Standards of medical / surgical practice
268974	29820	29805		20020101	*	1	CPT Manual or CMS manual coding instructions
269301	29821	29805		20020101	*	1	CPT Manual or CMS manual coding instructions
269304	29821	29820		19960101	*	1	HCPCS/CPT procedure code definition
269305	29821	29822		19960101	*	1	Standards of medical / surgical practice
269307	29821	29825		20170101	*	1	Standards of medical / surgical practice
269621	29822	29805		20020101	*	1	CPT Manual or CMS manual coding instructions
269625	29822	29820		19960101	*	1	More extensive procedure
269937	29823	29805		20020101	*	1	CPT Manual or CMS manual coding instructions
269940	29823	29[illegible]		19960101	*	1	More extensive procedure
269941	29823	29820		19960101	*	1	More extensive procedure
269942	29823	29821		20170101	*	1	More extensive procedure

0001M-25999 | 26010-36909 | 37140-60699 | 60000-R0075

56 of 605351 records found

20

Example: Requirements for separate reimbursement

Source:

CMS. *National Correct Coding Initiative Policy Manual*. Chapter 4 Surgery: Musculoskeletal System, § E, "Arthroscopy," subsection 7

"Shoulder arthroscopy procedures include limited debridement (e.g., CPT code 29822) even if the limited debridement is performed in a different area of the same shoulder than the other procedure. With 3 exceptions, shoulder arthroscopy procedures include extensive debridement (e.g., CPT code 29823) ... "

Continued on next slide…

21

Example: Requirements for separate reimbursement

Source:

CMS. *National Correct Coding Initiative Policy Manual*. Chapter 4 Surgery: Musculoskeletal System, § E, "Arthroscopy," subsection 7

Continued from previous slide -

"… even if the extensive debridement is performed in a different area of the same shoulder than the other procedure. CPT codes 29824 (Arthroscopic claviculectomy including distal articular surface), 29827 (Arthroscopic rotator cuff repair), and 29828 (Biceps tenodesis) may be reported separately with CPT code 29823 if the extensive debridement is performed in a different area of the same shoulder. "

22

NCCI PTP edit code pair consisting of 2 codes describing 2 shoulder arthroscopy procedures

6		01/01/2021 to 03/31/2021					
7							
8	Column 1	Column 2	*=in existence prior to 1996	Effective Date	Deletion Date *=no data	Modifier 0=not allowed 1=allowed	PTP Edit Rationale
9							
10							
11						9=not applicab	
58648	29819	29821		20170101	*	1	Standards of medical / surgical practice
58649	29819	29822		20170101	*	1	More extensive procedure
58650	29819	29825		20170101	*	1	Standards of medical / surgical practice
58974	29820	29805		20020101	*	1	CPT Manual or CMS manual coding instructions

Code	Code Service Description
29819	Arthroscopy, shoulder, surgical; with removal of loose body or foreign body
29822	Arthroscopy, shoulder, surgical; debridement, limited, 1 or 2 discrete structures (eg, humeral bone, humeral articular cartilage, glenoid bone, glenoid articular cartilage, biceps tendon, biceps anchor complex, labrum, articular capsule, articular side of the rotator cuff, bursal side of the rotator cuff, subacromial bursa, foreign body[ies])

23

Example: Requirements for separate reimbursement

Source:

CMS. *National Correct Coding Initiative Policy Manual*. Chapter 4 Surgery: Musculoskeletal System, § E, "Arthroscopy," subsection 4

Elements that must be documented:

- Arthroscopy of both shoulders was performed on the same day/same surgical session. (Likely?)
- Removal of foreign body was from one shoulder (left or right).
- Debridement of structures performed in the opposite (contralateral) shoulder.
- Operative report must address work done in both shoulders. For example: "…portals of the right shoulder were closed. Attention was then turned to the left shoulder, and…"

24

Example: Requirements for separate reimbursement

Source:

CMS. *National Correct Coding Initiative Policy Manual*. Chapter 4 Surgery: Musculoskeletal System, § E, "Arthroscopy," subsection 4

Example of claim coding to match the documentation:

* 29819-RT
* 29822-LT

Comment: Only submit this coding if work on both shoulders was performed and clearly documented in the operative report.

25

Learning Objective # 2

Define the correct way to make legal additions or corrections to the medical record.

26

Amended Medical Records

Late entries, addendums, or corrections to a medical record are legitimate occurrences in documentation of clinical services. A late entry, an addendum, or a correction to the medical record, bears the current date of that entry and is signed by the person making the addition or change.

Source: Noridian[1]

Noridian Medicare. "Documentation Guidelines - Amended Records." *Medicare B News*, Issue 207, October 14, 2003. June 27, 2014. <https://www.noridianmedicare.com/provider/updates/docs/doc_Guides_amend_records_reprint.pdf>.

27

Late Entry to the Medical Record

A **late entry** supplies additional information that was omitted from the original entry.

The late entry:

* Bears the current date.
* Is added as soon as possible.
* Is written only if the person documenting has total recall of the omitted information.

Example: A late entry following treatment of multiple trauma might add: "*The left foot was noted to be abraded laterally.*"

Noridian[1]

28

Addendum to the Medical Record

An **addendum** is used to provide information that was not available at the time of the original entry.

The addendum:

* Is added as soon as the new information becomes available. ("… should also be timely… ")
* Bears the current date the new information is added.
* Bears the reason for the addition or clarification of information being added to the medical record.

Example: An addendum could note: *"The chest x-ray report was reviewed and showed an enlarged cardiac silhouette."*

Noridian[1]

29

Correction to the Medical Record

(paper medical records)

When making a **correction** to the medical record:

* Never write over, or otherwise obliterate the passage when an entry to a medical record is made in error.
* Draw a single line through the erroneous information, keeping the original entry legible.
* Sign and date the deletion, stating the reason for correction above or in the margin.
* Document the correct information on the next line or space with the current date and time, making reference back to the original entry.

Noridian[1]

30

Correction to the Medical Record

(electronic medical records)

When making a **correction** to the medical record:

* Correction of electronic records should follow the same principles of tracking both the original entry and the correction with the current date, time and reason for the change.
* When a hard copy is generated from an electronic record, both records must be corrected.

Noridian[1]

31

Correction to the Medical Record

(any format - paper or electronic medical records)

Any corrected record submitted must make clear:

* The specific change made.
* The date of the change.
* The identity of the person making that entry. [e.g. name and licensure]

Noridian[1]

32

According to CMS & Noridian Medicare:

Adding to existing documentation (except as described in late entries, addendums and corrections) is considered falsification of medical records.

Noridian[1]

33

According to CMS & Noridian Medicare:

Corrections to the medical record legally amended prior to claims submission and/or medical review will be considered in determining the validity of services billed. If these changes appear in the record following payment determination based on medical review, only the original record will be reviewed in determining payment of services billed to Medicare.

Noridian[1]

34

Is it too late? (to make an amendment)

If corrections or additions need to be made after a payment determination (denial) has been made based on medical review,

then the changes should still be made if they are clinically significant,

even though the amendment will not improve the reimbursement of the claim/procedure code(s).

35

Purpose of the Medical Record

1. Record and document the patient's medical condition (symptoms, care given, response to treatment) for current and future care and healthcare clinicians.
2. Serve as a legal record of what happened.
3. To verify and support third-party reimbursement of services and procedure codes (from commercial, worker's compensation, or government insurance plans).

36

Participant Survey Question:

Which of the following is NOT required when making an addendum?

A. Document the date and time the change or addition is made.

B. Remove the original documentation that was in error.

C. State in the addendum the reason why the change or addition is being made.

D. Document the name and licensure of the person making the addendum to the medical record.

37

Participant Survey Question:

When making an addendum, when should the entry be made if reimbursement is desired?

A. As soon as possible.
B. Preferably before the claim is submitted.
C. Before a denial is received.
D. When preparing to send the appeal.
E. Before the provider has a chance to forget information from the patient encounter.
F. A, C, E.
G. D, E.
H. A, B, C, E.
I. All of the above.

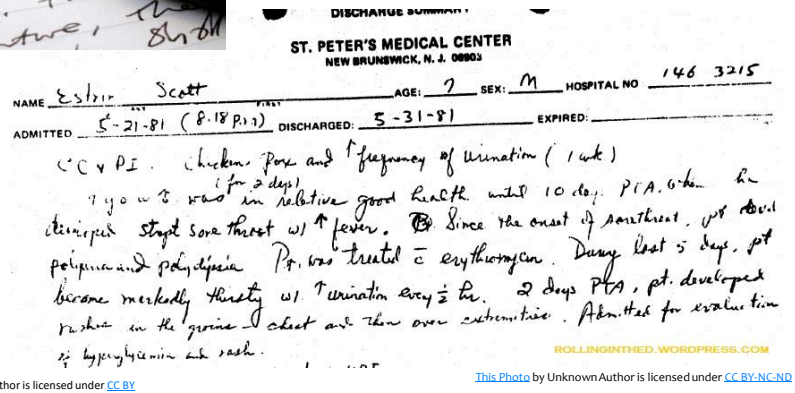
38

Learning Objective # 3

Identify common documentation problems that lead to denials and how to avoid them.

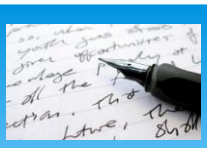
39

Problem: Illegible Medical Records



40

Problem: Illegible Medical Records

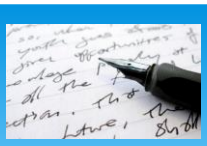


Medical records can be rendered illegible by:

- Poor handwriting.
- Obscuring portions of the record. Examples:
  - White out.
  - Black marker.
  - Use of highlighter pens (often read as black marker on copy or fax).
  - Post-it note covering portions of the record.
- Poor printer/copy quality.
- Problems with fax transmission.
  - Remember that faxed records are essentially an electronic copy of the original.
  - Copy quality issues apply.
  - Copies of copies especially do not fax well.

41

Problem: Illegible Medical Records

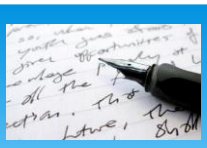


What is the acceptable standard?

- All entries must be legible to another reader to a degree that a meaningful review may be conducted.
- If the records cannot be read after review by three different persons, the documentation (or any unreadable portion) is considered illegible.

42

Problem: Illegible Medical Records



Not acceptable:

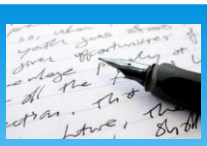
It is not acceptable to obscure portions of the record in any way (e.g. white-out, black-out marker, post-it note covering, etc.).

- This renders that portion of the record illegible and is an alteration of the medical record.
- When records are received with information obscured, services may be denied because:
  - A portion of the records are illegible and/or unreadable.
  - The records have been altered.
  - The reviewer is unable to verify that they have complete and accurate information upon which to base their determination.

(This comment does not apply to sanitizing social security numbers or other non-medical HIPAA-protected information from the documents submitted.)

43

Problem: Illegible Medical Records



Billed charges:

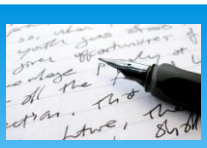
- **E1399** (Durable medical equipment, miscellaneous)
- **K0739** (Repair or nonroutine service for durable medical equipment other than oxygen equipment requiring the skill of a technician, labor component, per 15 minutes)

Reviewer's comments:

The newly submitted documentation included the physician order for some of the charges but the signature and date were difficult to read and illegible due to copying, so it cannot be determined what items were ordered. The documentation also included an invoice, but this was the manufacturer's invoice and not the requested patient invoice.

44

Problem:
Illegible Medical Records



The consequence of illegible records:

When illegible records are received, the services are considered not documented and therefore non-billable and cannot be reimbursed.

Illegible records = Not documented = Denial

45

Problem:
Incomplete medical records submitted

* When records are requested, it is important that you send all associated documentation that supports the services billed within the timeframe designated in the written request.
* The documentation of all services rendered is absolutely necessary in order for a claim to be properly evaluated.

Noridian[1]

46

Problem:
Incomplete medical records submitted

The "burden of proof" remains with the provider to substantiate services and/or supplies billed.

Source:
"Documentation Guidelines for Medicare Services." *Noridian Medicare.* September 15, 2013. May 18, 2017 https://med.noridianmedicare.com/web/jeb/cert-reviews/mr/documentation-guidelines-for-medicare-services

Noridian[2]

47

Problem:
Incomplete medical records submitted

* If there is no documentation, then there is no justification for the services or level of care billed.
* Additionally, if there is insufficient documentation on the claims that have already been adjudicated by Medicare, reimbursement may be considered an overpayment and the funds can be partially or fully recovered.

Noridian[1]

48

Problem:
Incomplete medical records submitted

* If the requested documents and information are not received within the required timeframe, the record is deemed not to exist, and the services not documented.
* If the documentation is incomplete or insufficient to support the services, then the service or item will be considered as not documented.

Moda Health Reimbursement Policy # RPM039

49

Problem:
… somebody else keeps the records for those services. Go ask them …

50

Problem:
… somebody else keeps the records for those services. Go ask them …

* At times some providers choose to house test reports or other elements of the documentation at a different location from the billing office or facility.

* This may happen with claims from/for:
  * Interpretation and report of tests performed in the hospital (e.g. radiology studies, EKG, etc.)
  * Ambulatory Surgery Centers (ASC) facility fees.
  * Laboratory services.

51

Problem:
… somebody else keeps the records for our services. Go ask them …

Best practice instructions:

Because the billing provider is required to submit documentation to support billed charges upon request, it would be best practice if both the physician and the facility keep a copy of the relevant reports in their records so that it is readily available when needed.

Source:
FCSO Medicare. "Documentation." *The Florida Medicare B Update*, third quarter 2006 (vol. 4, no. 3), pg. 3.

52

Problem:
… somebody else keeps the records for our services. Go ask them …

- Your office is responsible for obtaining a copy of the needed records from the other location/provider and submitting them within the timeframe specified in the request.
- When the response to a medical records request indicates the billing provider does not have a copy of the records to support the billed services/codes and instructs the health plan to contact another provider for the needed records, the services will be denied as not documented.

Moda Health Reimbursement Policy # RPM039

53

Problem:
Time not documented properly

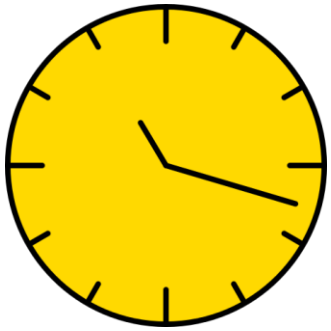
For any time-based procedure codes

(codes with descriptions that specify an increment of time such as minutes or hours)

the duration of the service must be clearly documented in the medical record.

54

Problem:
Time not documented properly



If more than one procedure code is billed for the same date of service (e.g. multiple therapeutic codes or E/M combined with a procedure), then in order to fully support all of the billed services the time must be separately documented for each specific procedure or time-based service. This will clearly document what portion of the total visit was spent performing each of the billed codes.

55

Problem:
Time not documented properly

Acceptable time documentation:

* Specific number of minutes.

  Example: "Manual therapy to lumbar spine x 15 minutes."

* Listing begin-time and end-time for service.

  Example: "E-stim to cervical neck, 09:30 – 09:45."

56

Problem:
Time not documented properly

Unacceptable time documentation:

* Time must be reported in full one-minute increments. Any fractions of less than one-minute will not be considered in the review.

57

Problem:
Time not documented properly

Unacceptable time documentation:

* Documenting time in terms of "units".
  Examples: "One unit of pulsed ultrasound was administered."
  "Ther Ex 1 unit."

* Documenting time using a range.
  Example:
  "Therapeutic activities x 6 – 12 minutes as appropriate per assessment and symptoms."

58

Problem:
Time not documented properly

Unacceptable time documentation:

* Documenting a quantity but not specifying the measurement or increment used.
  Example: "97110 Exercises x 2"
* No time mentioned at all.
  Example:
  Checking or circling "NMR" or "TE" on a chart form with no additional information documented.

59

Problem:
Time not documented properly

Time not documented = Service not documented = Denial

If the duration of the time-based service is not clearly and properly documented in the medical record, then the service is not supported due to incomplete documentation; the procedure code will be denied as not documented.

60

Problem:
Key information is missing

Records may be submitted for the visit or procedure, but if key information is missing, the service may still be considered "not documented" or "not supported."

61

Problem:
Key information is missing

Required Information – Medical Record Entries must:	Missing Information – Medical Record Entry With:

* Be signed by the rendering provider with:
  * Full name
  * Licensure
  * Date
  * Time
	* Entry is missing the provider signature.
	Or the signature does not indicate a licensure.
	Or the signature is not dated and timed.

62

Problem: Key information is missing

For more information about signature requirements, see:

- "Documentation Guidelines for Medicare Services." *Noridian Medicare.* September 15, 2013. May 18, 2017 https://med.noridianmedicare.com/web/jeb/cert-reviews/mr/documentation-guidelines-for-medicare-services
- Noridian Medicare. "Signature Requirements." Last accessed May 18, 2017. https://med.noridianmedicare.com/web/jeb/cert-reviews/signature-requirements .
- CMS. "Signature Attestation Statement." *Medicare Program Integrity Manual*. Publication 100-08, chapter§ 3.3.2.4.C. 3,

63

Problem: Key information is missing

Required Information – Medical Record Entries must:	Missing Information – Medical Record Entry With:
* Be specific to the patient.	* No patient name listed in header or footer.
* Indicate the date of service.	* Date of service not listed or indicated, although services are documented with provider signature.
* Time – See separate item above.	* Time – See separate item above.
* Orders for tests, infusion drugs, DME items, or other services must be dated on or before the date of service for those items	* Claim for home infusion antibiotics for 10/1/2020 – 10/31/2020. Physician orders submitted are for that drug and amount but dated 11/4/2020.

64

Problem: Key information is missing

Required Information – Medical Record Entries must:	Missing Information – Medical Record Entry With:
* Order or requisition is signed and dated by the ordering provider.	* The requisition sheet does not have a signature from the ordering provider.
* Time – See separate item above.	* Time – See separate item above.

* Measurements or amounts must be documented when code selection is based on measurements.
  * Lesion removal.
  * Wound repair codes.
  * Hysterectomy codes.
	* The measurement of a lesion or wound is not documented. Or the weight of the uterus removed is not documented.

65

Problem: Date of service doesn't match

The date of service on the claim needs to match the date of service in the medical records.

When the date of service on the claim is different than the date of service in the record this can cause a denial for "not documented" on the date billed.

Here are some situations with special date of service requirements:

* Maternity – Antepartum care & postpartum care (59425, 59426, 59430) are billed with the date of delivery.
* Split surgical care (modifiers 54 & 55). Post operative care (-55) is billed with the surgical code and the surgical date of service.
* DME – Date of service = date of delivery

66

Problem: No proof of delivery

Proof of delivery is needed for any tangible supply or item which is not a professional service. This includes but is not limited to:
DME, supplies, self-administered drugs, home infusion therapy supplies, orthotics, etc.

Methods of Delivery

* Delivery directly to the member/patient or authorized representative (includes patient pick-up at the office).
* Delivery via shipping or delivery service.
* Delivery of items to a nursing facility on behalf of the member/patient.

Proof of delivery (POD) is a Supplier Standard. Suppliers are required to maintain proof of delivery documentation in their files, and to provide the documentation upon request. (Noridian)

67

Problem: No proof of delivery

For more information about proof of delivery (POD) requirements, see:

* Noridian Medicare. "Proof of Delivery." Last accessed September 27, 2017. https://med.noridianmedicare.com/web/jddme/topics/documentation/proof-of-delivery .
* Noridian Medicare. "Avoiding CERT denials for Proof of Delivery." Last accessed 8/22/2017. https://med.noridianmedicare.com/web/jddme/avoiding-cert-denials-for-proof-of-delivery .
* Noridian Medicare. "Proof of Delivery - Requirements for Signature and Date." Last accessed 8/22/2017. https://med.noridianmedicare.com/web/jddme/policies/dmd-articles/proof-of-delivery-requirements-for-signature-and-date .

68

Problem: Cloning of medical record entries

69

Problem: Cloning of medical record entries

Medical records documentation is considered cloned when:

* Multiple entries in a patient chart are identical or similar to other entries in the same chart.

70

Problem: Cloning of medical record entries

Medical records documentation is considered cloned when:

* Entries in the medical record are identical or similar from patient to patient to patient, without expected unique variations. It would not be expected that every patient had the exact same problem, symptoms, and required the exact same treatment.

71

Problem: Cloning of medical record entries

Medical records documentation is considered cloned when:

* Information from previous entries of the same provider or other providers is pulled forward into the current entry, particularly when it is not updated or not relevant to the current encounter.

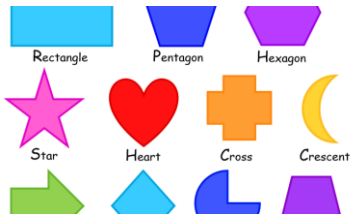
72

Problem: Cloning of medical record entries

In other words,

* copying and pasting
* pulling forward information
* the use of macros or templates

could all be considered cloning.



73

Problem: Cloning of medical record entries

A real-life example:

Surgical Documentation

The arthroscopic portal wounds were then cleaned and closed with 3-0 monocryl in standard buried arthroscopic portal stitch fashion. The biceps tenodesis wound was closed in layered fashion with 2-0 monocryl for the subdermis in simple, buried, interrupted fashion, and 3-0monocryl for the subcutaneous layer in running subcuticular fasion.The portal wounds were dressed with steri-strips, gauze, ABD and medipore tape dressings. The biceps tenodesis wound was dressed with gauze, and tegaderm. The arm was placed in a sling and abduction pillow.

The patient was transitioned out of beach chair position back to supine and awoken from anesthesia without complication. Patient was transferred back to their hospital cart and PACU in stable condition.

During surgery, a physician assistant provided services including patient positioning, prep and drape, manipulation of the extremity, retraction, assistance with tissue preparation and/or implant placement, wound closure and post-operative dressing placement. This significantly decreased operative time, facilitated the procedure, and assisted in managing any coexisting morbidities.

POST-OP Care:
1. NWB LUE - ok for elbow/wrist ROM - no resisted elbow flexion or supination
2. ASA 81 mg PO daily for post-operative DVT ppt
3. Prescription for pain previously provided
4. Follow-up in clinic within 1 week

Electronically Signed on 09/18/20 06:24 PM

74

What is the acceptable standard?

All documentation in the medical record must:

* Be specific to the patient.
* Be specific to the situation at the time of the encounter.
* Accurately reflect the services performed.
* Support the necessity for the services.
* Clearly identify who performed the services and assessments documented.
* Clearly identify the author of each note or entry.
* Clearly identify the date and time the entry was made.

75

Cloned entries damage the integrity of the medical record

* Cloned medical records entries are not reliable as an accurate record of the events and services depicted.
* Cloned documentation is considered a misrepresentation of the events and services in that entry and a falsification of the medical record. (Source: FCSO Medicare. "Cloning of Medical Notes." *The Florida Medicare B Update*, third quarter 2006 (vol. 4, no. 3), pg. 4.)
* When cloned documentation is found, the accuracy and validity of the entire entry is damaged. Other entries in the record may also become suspect. (Source: McKimmy, Roger, MD, Oregon Medical Board Vice Chair. "The Pitfalls of Electronic Medical Records." *Oregon Medical Board Report.* Vol. 124, No. 4, Fall 2012: pp. 1, 8-9. http://www.oregon.gov/omb/Newsletter/Fall%202012.pdf.)

76

Consequences of cloned medical record documentation:

* Services are considered not documented when cloned documentation is found or identified, and services will be denied due to the lack of supporting documentation.
* If services have previously been allowed, refund requests and recoupment of payment may occur.

77

Questions?

78

Contact information:

Kimberly Haas, CPC
kimberly.haas@modahealth.com

79

All graphics are publicly searchable free clip art
or
are sourced from Bing online pictures search under creative commons results.

80