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ERG

Documentation Presentation

2019

Because Experience Matters...

DuvaSawko is owned and operated by ED Physicians *for* ED Physicians.

Charles D. 'Chuck' Duva, MD CMM FACEP
Chief Executive Officer

William 'Bill' Sawko, MD FACEP
Vice President & CIO

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CREDENTIALS / EXPERIENCE

Credentials / Experience

Nettie McFarland, RHIT, CCS-P, CHC

- RHIT - Registered Health Information Technician
  - American Health Information Management Association (AHIMA)
- CCS-P – Certified Coding Specialist – Physician
  - AHIMA
- CHC – Certified Healthcare Compliance
  - Healthcare Compliance Association (HCCA)
- 22 years experience outpatient coding
- 4 years experience hospital HIM department
- 10 years experience HIM/coding education
- 13 years experience Healthcare Compliance

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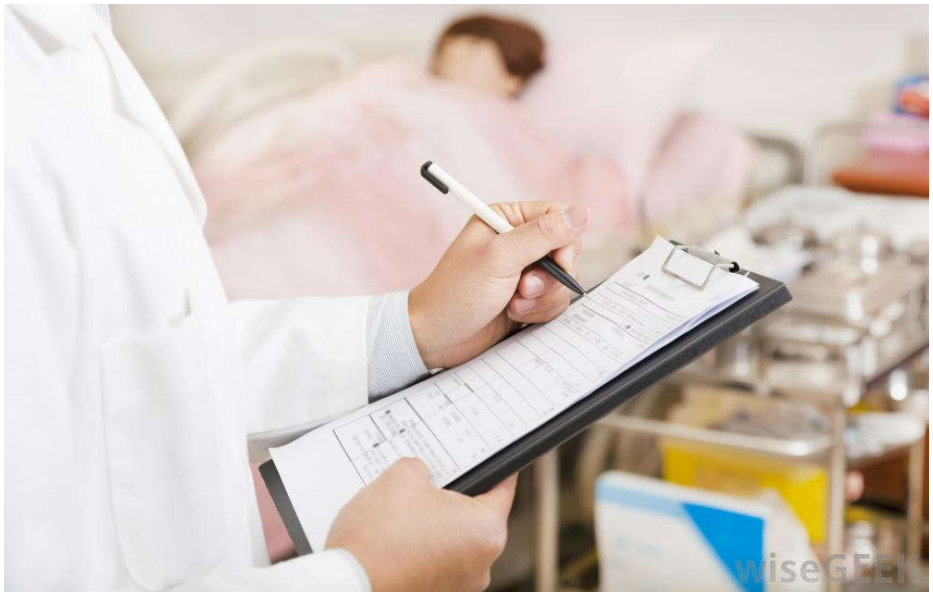
Components of Evaluation and Management Documentation



Components of E/M

- History
  - History of Present Illness (HPI)
  - Review of Systems (ROS)
  - Past, Family, Social Hx (PFSH)
- Physical Exam
- Medical Decision Making
  - Diagnosis and Management Options
  - Amount and Complexity of Data
  - Overall Risk

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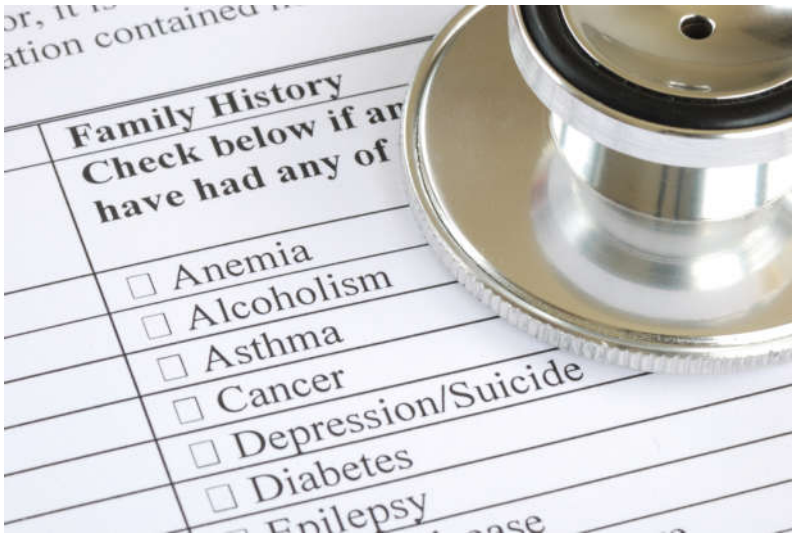
History



Elements of History

- Chief Complaint
- HPI – History of present illness (ED Provider only)
  - Location – diffuse or localized, unilateral or bilateral, fixed or migratory
  - Quality – sharp, dull, throbbing, stabbing, constant, intermediate
  - Severity – pain level, severity of injury
  - Timing – nocturnal, continuous, repetitive pattern
  - Duration – how long
  - Context – cause, surrounding events
  - Modifying factors – current medications, what makes it worse or better
  - Associated signs or symptoms
- PFSH – Past medical, family and/or social history
- Inability to document history; document the reason

Elements of History (cont)

ROS – Review of systems

Constitutional	Musculoskeletal
Eyes	Integumentary
Ears, nose, throat (ENT)	Neurological
Cardiovascular	Psychiatric
Respiratory	Endocrine
Gastrointestinal	Hematological/lymphatic
Genitourinary	Allergic/immunologic

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Physical Examination

Physical Examination

- 99281 – 99284
  - Body Areas and/or
  - Body Systems
- 99285
  - Body Systems ONLY
- Document
  - Specific abnormalities of Affected Systems
  - Specific abnormalities of Other Systems
  - “Normal” or “Negative” allowed for all unaffected systems

Organ Systems

- Constitutional
- Eyes
- Ears, nose, mouth and throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Skin
- Neurological
- Psychiatric
- Hematology/lymphatic/immunologic

Body Areas

- Head, including the face
- Neck
- Chest, including breasts and axillae
- Abdomen
- Genitalia, groin, buttocks
- Back, including spine
- Each extremity

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ED E&M Guidelines

99285

HX: comprehensive

HPI – 4 elements required

ROS – 10 systems required

- Document:
  - Positives
  - Pertinent Negatives
  - All other systems are reviewed and negative

PFSH – 2 required

PE: comprehensive

Exam – 8 systems required

99284

HX: detailed

HPI – 4 elements required

ROS – 2 systems required

PFSH– 1 required

PE: detailed

Exam – 6 systems recommended

99283

HX: expanded problem focused

HPI – 1 element required

ROS – 1 system required

PE: expanded problem focused

Exam – 2 required

99282

HX: expanded problem focused

HPI – 1 element required

ROS – 1 system required

PE: expanded problem focused

Exam – 2 systems required

99281

HX: problem focused

HPI – 1 element required

ROS – no requirement

PE: problem focused

Exam – 1 system required

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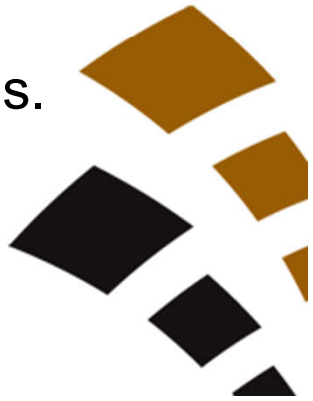
Medical Decision Making

Medical Decision Making

- Number of possible diagnoses and number of management options considered
- Complexity of medical records, tests and other information obtained, reviewed and analyzed
- Risk of complications, morbidity, mortality as well as comorbidites associated with patient's presenting problems, diagnostic procedures and management options

Diagnosis and Management Options

- Document co-morbidities or other symptomatic problems
  - Each additional problem worth additional points
- For a presenting problem with an established diagnosis, the record should reflect whether the problem is:
  - Improved, well controlled, resolving, or resolved
  - Inadequately controlled, worsening, or failing to change as expected
- For a presenting problem without an established diagnosis, including differential diagnoses can support the decision process of the provider.
- If further work up is planned after discharge, document this.
- Document all referrals or consultations



Amount and Complexity of Data

- Medical necessity of diagnostic services should be clearly documented.
- Document:
  - Direct visualization and independent interpretation of an image, tracing or specimen.
  - Discussions of laboratory, radiology or other diagnostic tests with the physician who performed or interpreted the study.
  - Relevant findings from the review of old records, and/or additional history from family, caretaker or other source.
  - Conversations with primary care providers and/or consultants
  - If you obtain history from source other than patient.

Overall Risk

- Document
  - When a patient requires urgent evaluation
  - Why reassessments are done
    - Include specific exam elements
  - Route medications are given
  - Comorbidities and other factors that increase risk
  - Urgency of any procedure that must be done immediately
  - Any changes in neurologic status
  - Undiagnosed problem with uncertain prognosis

Medical Decision Making

- Document if the patient has been referred by PCP or UCC.
- If a patient is high risk, document why
  - MVA
    - Some auto carriers now require a note of “Emergency Medical Condition” (EMC)
  - Psychiatric patient
- Medical necessity of admission
  - COPD exacerbation admitted due to increased O2 requirement, abnormal CXR, need for serial cardiac markers, etc.
- Document patient response to treatment

Emergency Medical Condition

- EMC Attestation:
  - I hereby attest that upon arrival in the Emergency Department, the patient met the definition of an Emergency Medical Condition.
- Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity, which many include severe pain, such that the absence of immediate attention could reasonably be expected to result in any of the following
  - Serious jeopardy to patient health
  - Serious jeopardy to bodily functions
  - Serious dysfunction of any bodily organ or part.

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DuvaSawko Guidelines for Coding Consistency

Guidelines for Coding Consistency

To ensure coding consistency, DuvaSawko has developed guidelines to determine the difference between levels.

All documentation of history, exam and medical decision making **must** support the use of any code.

99281

- Rechecks for *E&M visits* with no further treatment needed
- Visits where patient is told to rest or increase fluids
- Return for suture removal with no complications
    - 2011: CMS removed global days

99282

- At discharge, instruction to take OTC medications
- No ancillary studies
- No medications in ED
- No Rx on discharge
- No consultations

99283

- Medication in ED regardless of dosage
- Rx on discharge or Rx management
- 1 to 3 ancillary studies
- Temp ≥ 100.5 F or 38 C
- Strapping/splinting/sling ordered
- Consult/conversation with provider not in group
- Pregnant patient with any complaint
- Any condition where a minor neuro exam is pertinent:
  - Trauma, dizziness, headache

99284

- Any three items combined from 99283
- 4 or more ancillary studies
- Any special study: CT, MRI, MRA, bladder scan, Doppler studies
- IV fluids and or medications
- 2 IM non-controlled medications
- 1 IM controlled medication
- IM/SQ medication with any ancillary studies
- Multiple nebulizer medications
- Trauma patients arriving via EMS
- Pelvic pain or vaginal discharge with pelvic exam
- Observation of post-traumatic pregnant patient

99285

- Admissions
- Involuntary commitments
- Two or more special studies
- Work ups that include all of the following: radiology, labs, and EKG's with interpretation by ER MD
- Making patient's status "DNR"
- Threatened abortion
- Chest or abdominal pain, or shortness of breath with any 3:
  - Three or more ancillary studies
  - Any IV or IM/SQ med
  - IV fluids
  - Special study
  - Two or more nebulizer medications
- Any complaint and combination of:
  - IV fluid
  - Any IV or IM/SQ med
  - Three or more ancillary studies
  - Special Study

Diagnosis

- List any differential being considered
  - Based on… I doubt…
    - EKG unchanged, no exertional component to symptoms, I doubt ACS
- List all co-morbidities that co-exist at the time of the visit
- List potential complications and/or serious diagnosis especially in seemingly minor complaints
  - Upper respiratory illness in pediatric patient with potential for respiratory distress
- Use explanatory words to better describe the medical condition
  - Acute
  - Uncontrolled
  - Severe
  - Exacerbation

Low Acuity Diagnoses

- **Viral Infection**
- **Anemia**
- **Otitis Media**
- **Streptococcal pharyngitis**
- **Influenza**
- **Constipation**
- **Cellulitis**
- **Urinary Tract Infection**
- **Dysuria**
- **Cough**
- **Nausea and/or Vomiting**
- **Diarrhea**
- **Rash**

- Use of “acute” helps support medical necessity.
- Document if sent by PCP or UCC
- Use also:
  - Fever
  - Pain
  - Weakness

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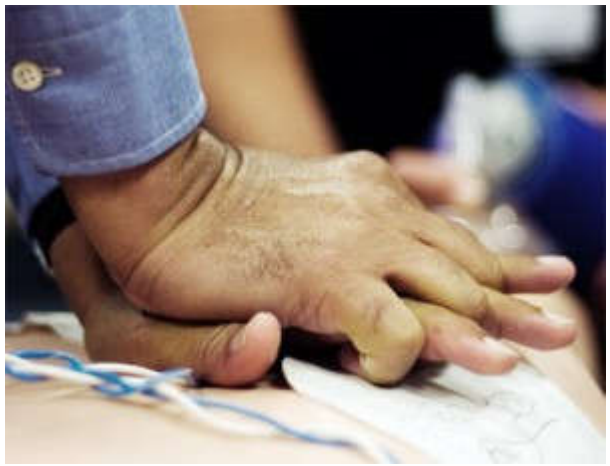
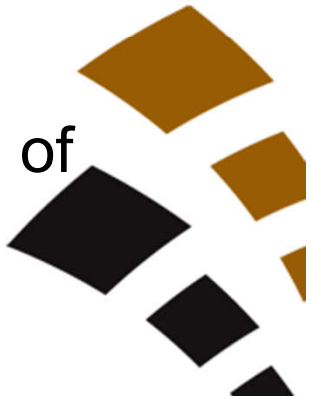
Critical Care Services
And
Medical Necessity



Critical Care - CPT

Definition: ***A critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the patient's condition.***

- Is the direct delivery by a physician(s) of medical care for the critically ill or critically injured patient.
- Involves high complexity decision making to assess, manipulate and support vital system function(s) to treat single or multiple vital organ system failure and/or prevent further life threatening deterioration of the patient's condition.



Critical Care - CMS

Medicare Claims Processing Manual

Chapter 12 - Physicians/Nonphysician Practitioners 30.6.12 - Critical Care Visits and Neonatal Intensive Care (Codes 99291 - 99292)

Critical care services encompass both treatment of "vital organ failure" and "prevention of further life threatening deterioration of the patient's condition."

- May be delivered in a moment of crisis or upon being called to the patient's bedside emergently, but is not a requirement for providing critical care service.
- Treatment and management of the condition, while not necessarily emergent, shall be required, based on the threat of imminent deterioration.

Critical Care Questions

- Ask the following questions to determine critical care
  - Is there at least one vital organ system acutely impaired?
  - Is there a high probability of imminent, life threatening deterioration?
  - Did you intervene to prevent further deterioration?

Critical Care

- CMS requires the verbiage of time “excluding all procedures”
- History caveat
  - Unable to obtain history due to _____
- Documentation should include
  - Organ system at risk
  - Frequent reassessments
  - Likelihood of life threatening deterioration
- Documentation to avoid
  - “NAD”
  - Normal vs _____
  - Resting comfortably

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Split/Shared Evaluation and Management Service

Split/Shared E&M Defined

For CMS, Medicare Part B, the supporting medical records must satisfy the documentation requirements.

Additionally, Section 30.6.13 (H), *"A split/shared E&M visit is defined by Medicare Part B payment policy as a medically necessary encounter with a patient where of an E&M visit face-to-face with the* ***physician and a qualified NPP each personally perform a substantive portion*** *same patient on the same date of service. A substantive portion of an E&M visit involves all or some portion of the history, exam or medical decision making key components of an E&M service."*

Split/Shared Documentation

- The physician should document patient specific information for the following areas of the chart:
  - History
  - Exam
  - Medical decision making.
- In addition, it must be noted that the mid-level documentation was reviewed and agreed with, this can be done in a blanket attestation statement (Macro.)

Example of Complete Documentation

The patient presents with left-sided chest pain for two weeks. Somewhat tender to palpation. Seen in urgent care, referred here due to a concern over possible blood clot. Does have tenderness to palpation across the left anterior chest but clear lungs and normal heart sounds. D-dimer is slightly elevated. The other labs are normal. Chest x-ray is clear. Will proceed with CT for PE. If negative the patient will be able to be discharged home. Does appear to be quite stable.

I have reviewed the non-physician practitioner's documentation and am in agreement, met with the patient face to face, made the diagnosis, and the medical decision making was done by me.

Dr X

Split/Shared and Critical Care

- Critical care cannot be representative of a combined service between a physician and a qualified non-physician provider
- Only 1 provider can receive credit
- The provider must documented critical care time themselves.

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Procedure Documentation

Procedure Documentation

- Any and all procedures performed by the physician or MLP must be documented by that provider
- Only the provider performing procedure can be billed. Procedures are not part of a split/shared service.
- Provider agreement with nursing documentation is unacceptable and insufficient to code and bill.

Laceration Repairs

- Length and location of each laceration in centimeters
- Extensive cleaning, debridement and removal of foreign bodies
- Layered closure for each laceration when appropriate
- Dermabond and other tissue adhesives qualify as repair
- Scalp and forehead measured separately

Integumentary Procedures

Abscess Procedures

- Incision and Drainage
  - Without packing
  - With packing
- Puncture Aspiration

Debridement measurement and depth must be given:

- Epidermis, dermis
- Subcutaneous tissue
- Muscle and/or fascia
- Bone

Procedures

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- Some procedures are typically performed by ancillary staff such as nursing or orthopedic technicians. If these procedures are done by you, it is important to document this clearly.
- Without clear documentation, the coders will not know to capture the procedures in coding
- Examples:
  - Splints
  - Foley catheter insertion
  - Nasogastric tube

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DOWNCODING

Total Percent of Downcodes

January	February
0.29%	0.38%

*DuvaSawko client average is 1%

Downcode Distribution

2019 Year to Date

Insufficient	HPI	ROS	PFSH	PE
Lost RVUs	120.39	154.03	10.58	100.74
Lost Charge	$23,106	$36,210	$2,390	$23,151
Percentage	31%	40%	3%	26%

YTD Total Lost Charges:
$84,857

Downcode Process Overview

Downcode Report (post-billing):

- When a coder encounters a chart where all sections are complete, but the documentation is insufficient to support the appropriate level, the chart is coded to the highest level of documentation.
- A memo is added to the patient account indicating:
  - which portion of the chart was insufficient
  - how many elements were documented relative to how many elements were needed (example: Insufficient ROS 7/10)
  - the associated lost charges
- Informational data is also supplied in this report to educate providers in improving documentation to capture Critical Care, missed procedures, or capture other billable procedures.

Downcode Report

Fac ID	Category	Memo Text	Visit Level	Service Date	Provider Name	Account Number	Lost Charges	Lost RVU's
	Downcoded L4	Insufficient HPI 3/4	L3	12/13/2017			$344	0.94
	Downcoded L4	Insufficient HPI 2/4	L3	12/24/2017			$344	0.94
	Downcoded L5	Insufficient ROS 9/10	L4	01/07/2018			$346	1.48
	Downcoded L4	Insufficient HPI 1/4	L3	12/19/2017			$344	0.94
	Downcoded L4	Insufficient HPI 2/4	L3	12/23/2017			$344	0.94
	Downcoded L5	Insufficient HPI 2/4	L3	01/10/2018			$690	2.42
	Downcoded L5	Insufficient PE 7/8	L4	01/01/2018			$346	1.48
	Informational	potential critical care	L5	12/15/2017				
	Informational	potential critical care	L5	12/15/2017				
	Informational	potential critical care	L5	12/23/2017				

History of the Present Illness (HPI)

"This is a 40-year-old male who arrives ambulatory to the emergency department with his wife. The patient was working at O'Hare on Thursday and came home to do some construction around the house where he was on his knees a bit. On Friday, he woke up with red, swollen, and a warm right knee. He was seen by Dr. Mehta at the office. He had both an incision and drainage and a tap that had no drainage expressed per the patient. He had redness and swelling at that point which was limited to just around the patella. He was placed on Keflex. He has taken a total of 48 hours of Keflex. He had a fever of 101 today. He has had increasing pain with range of motion, increased redness, warmth, and a fever. He denies chest pain. He denies shortness of breath. He denies myalgia. Other than the above, there are no other physical complaints."

Review of Systems (ROS):

1. **Constitutional: Positive for fever and chills.**
2. **HENT: Negative.**
3. **Eyes: Negative.**
4. **Musculoskeletal: Positive for myalgias and joint swelling.**
5. **Skin: Erythema, tender and warmth to LLE**
6. **Hematological: Negative.**
7. **Psychiatric/Behavioral: Negative.**

In Summary

- Documentation is key for correct coding and reimbursement
- MDM drives the level of care
- Document what you do
  - Direct visualization
  - Independent interpretation
  - Discussions with other providers
  - Differential diagnoses
  - Summaries of previous visits
  - Procedures

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My contact information:

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THANK YOU!

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