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Medical Record Documentation Fundamentals

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Today's Presenters

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Learning Objectives

- Compliance – Fraud and Abuse
- Medical Necessity
- Quality Documentation Standards
- Introduction to ICD-10-CM Code Sets
- Introduction to CPT & HCPCS
- Understanding Modifiers & Place of Service Codes
- Evaluation & Management
- Medical Decision Making

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Coding and Compliance

Proper coding and documentation is essential for proper billing and payment.

Understanding billing and coding guidelines help **prevent instances of fraud and abuse** as well as accurate documentation of medical services.

Fraud, Waste & Abuse

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FRAUD:

Knowingly billing for services not furnished, supplies not provided, or both, including falsifying records to show delivery of such items or billing Medicare for appointments that the patient failed to keep. *-MLN: ICN 068627 August 2014*

WASTE:

Activities that do not add value to patient care but result in avoidable spending.

ABUSE:

Unintentional mistakes that do not follow published rules resulting in unnecessary spending.

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Medical Necessity

- It is essential that the medical necessity for all medical services be documented in the patient chart.
- Not only to receive payment, but obviously based on the requirements for the CPT code billed.
- It is NEVER appropriate to bill a higher/lower level of service if you cannot document Medical Necessity.

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Keys to Demonstrating Medical Necessity

- Document all diagnoses the provider is managing during the current encounter
- For each established diagnosis, specify if the patient's condition is stable, improved, worsening etc.
- Articulate a description of the condition when using other specified or unspecified ICD-10 codes
- Clearly describe management of the patient, i.e., OTC meds, RX meds, referrals, etc.

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QUALITY DOCUMENTATION

Quality Documentation

Quality assurance in patient care is only evident if it is documented in the medical record.

Quality services may have been provided; however if this is not evident within the medical records, issues may arise.

The OIG acknowledges that patient care is and ***SHOULD BE*** the priority. However, the practice's focus on patient care can be enhanced by the adoption of a compliance program.

The increased accuracy of documentation that may result from a compliance program will actually assist in enhancing patient care.

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Quality Documentation Standards

Documentation for each encounter should be:

- ✓Complete and legible
- ✓Consistent
- ✓Timely Manner
- ✓Include :
  - Reason for encounter (session topics, goals, etc.)
  - Assessment / Impression
  - Treatment plan / Goals
- ✓Date
- ✓Provider signature and credentials. (Rubber stamps are not acceptable)

PATIENT CENTERED DOCUMENTATION

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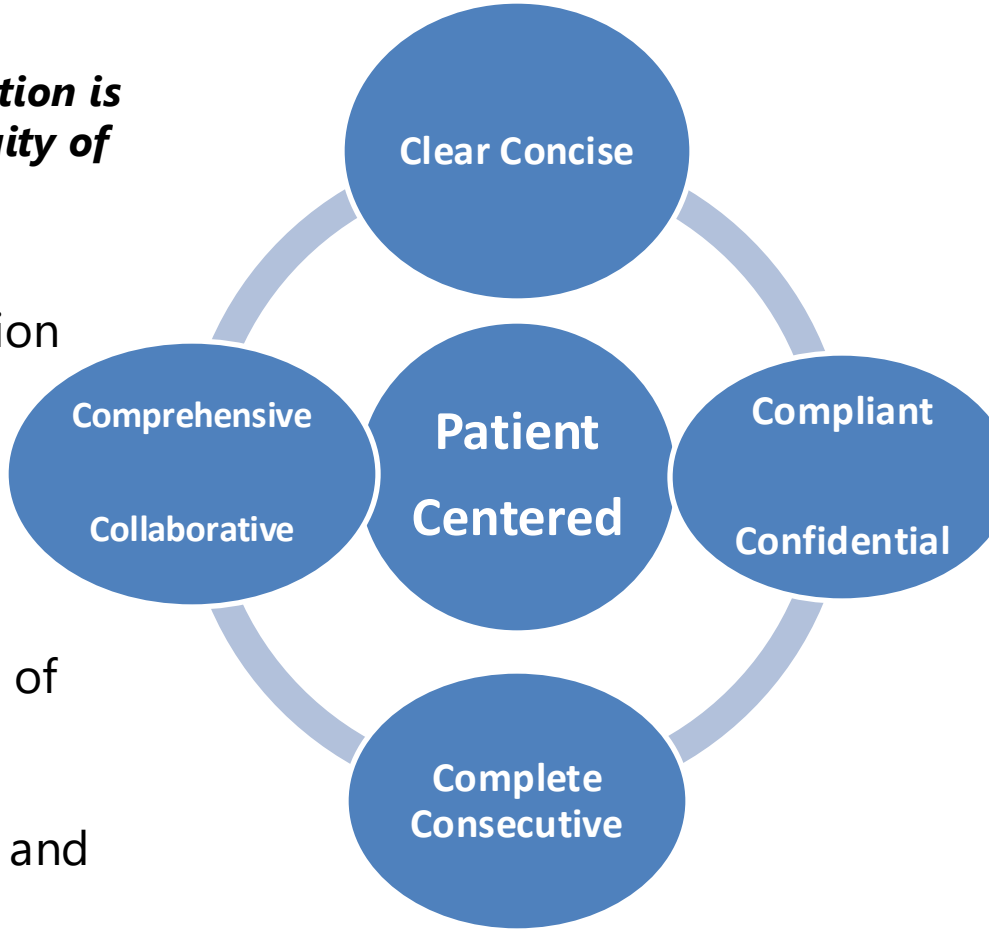
The main purpose of medical documentation is to promote the highest quality of continuity of care.

- Improve communication of information between ALL providers of service
- Provide the appropriate treatment, intervention and plan of care
- Improve goal setting and evaluation of care outcomes
- Improve early detection of problems and changes in status
- Provide EVIDENCE of excellent patient care



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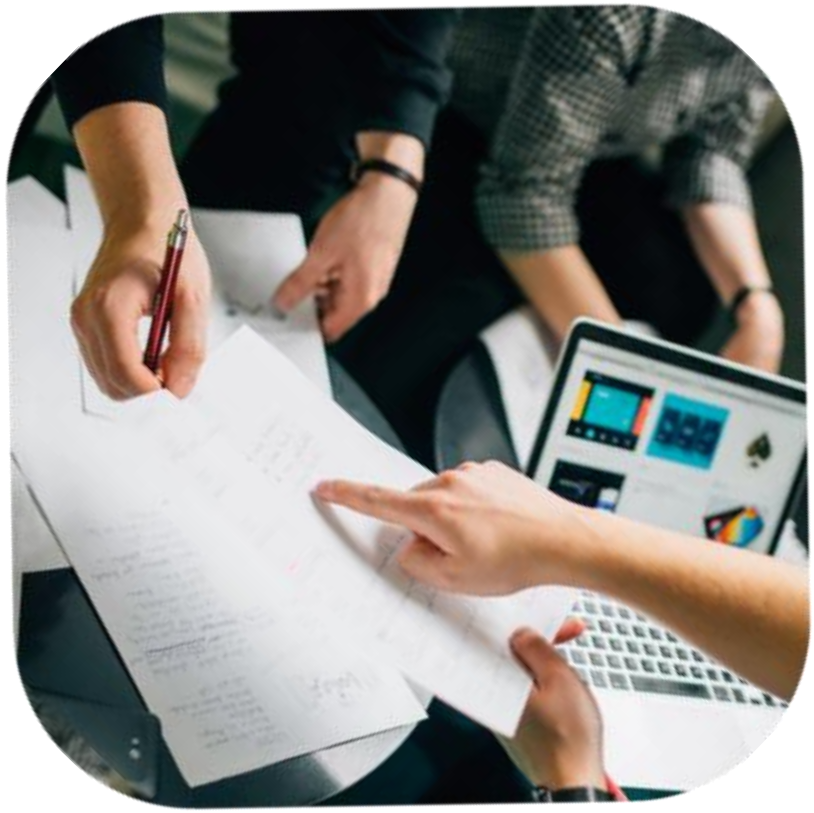
CONTINUATION OF CARE

"Documentation is only good if the next physician who treats the patient can pick up your record and know exactly what happened"



Rhonda Buckholtz**, CPC, CPMA, CPCI, CPEDC, COBGC, COGC, CENTC – **American Academy of Professional Coders

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Clinical Documentation Standards

How Comprehensive is Your Documentation?

Does the medical record :

- ✓Stand alone?
- ✓Provide evidence of nature and severity of the patient's condition
- ✓Provide evidence of services rendered
- ✓Indicate provider's assessment and plan complete enough for another clinician to take over the case. Past and Present conditions
- ✓Provide comprehensive information to protect the provider in court?

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Documentation Standards Continued

- ✓ The note should include "MEAT" for each diagnosis. - Monitor, Evaluate Assess/Address and Treatment plan
- ✓ Relevant health risk factors should be identified. Including personal and family history
- ✓ Medication list should be reconciled at each visit
- ✓ Use medical abbreviations sparingly as some of the abbreviations may mean multiple conditions

COPY AND PASTE

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Copy and Paste - While copying information from previous clinical notes can be of value, the practice should be used prudently, with the goal of producing a clear, useful, and accurate patient note

Indiscriminate use of copying and pasting and templates may compromise patient care and increase liability risk by **adding information that is unnecessary**

Duplicating information makes it more difficult for others to access needed data

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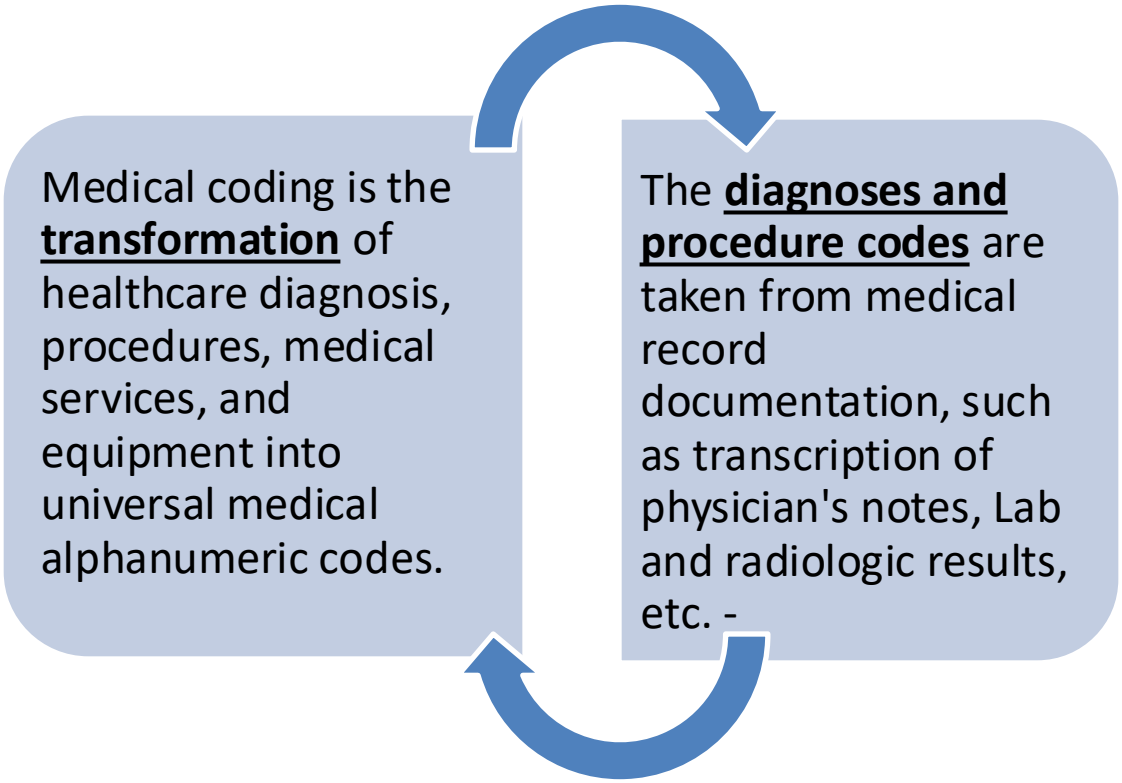
Converting Medical Documentation into Code Sets



Coding includes **abstracting the information** from documentation, assigning the appropriate codes, and creating a claim. –American Academy of Professional Coders (AAPC)

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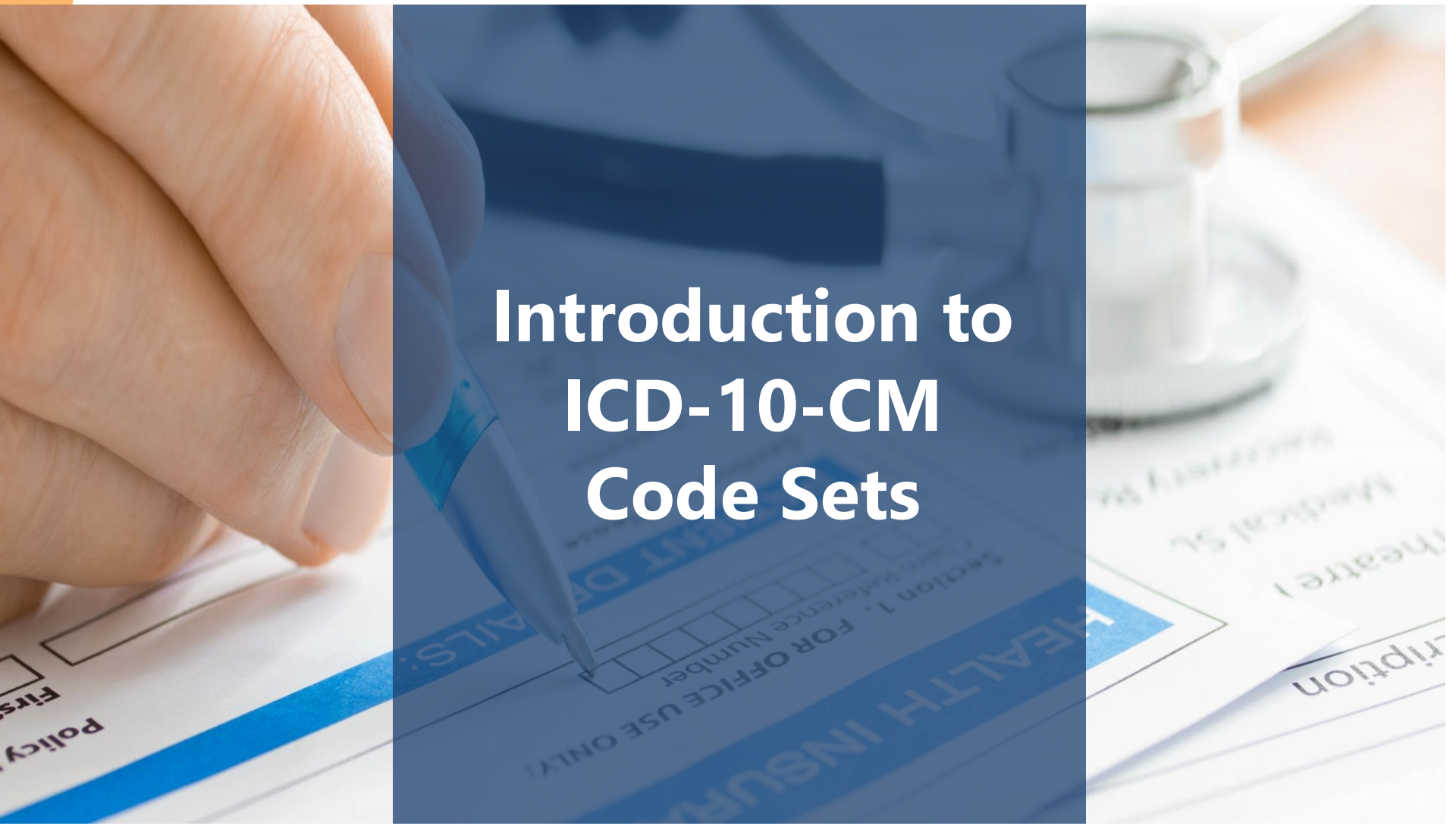

Introduction to ICD-10-CM Code Sets

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WHAT IS ICD-10-CM?

- ✓ The ICD-10-CM International Classification of Disease-10 revision
- ✓ Standardized system used to classify medical diagnosis, symptoms, injury, drugs and complications for both inpatient and outpatient
- ✓ The World Health Organization (WHO) and the Nation Center for Health Statistics (NCHS) at the Centers for Disease Control and Prevention (CDC) develop and maintain ICD-10-CM.
- ✓ CDC & CMS updates the guidelines semi-annually and annually

Selecting the Appropriate Diagnosis Code

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- Diagnosis codes must be complete – 3, 4, 5, 6, or 7 characters to the **greatest specificity.** The final level is a complete code.

- Diagnosis codes should be listed in order of severity - The primary diagnosis should be listed first, followed by the secondary, tertiary and so on.

- Each medical service, surgical procedure and/or diagnostic procedure should be matched with a corresponding diagnostic code.

Selecting the Appropriate Diagnosis Code Continued

- Providers should select the appropriate ICD-10 codes to describe the patient's diagnosis, symptoms, complaint, condition or problem indicating why the medical service was performed. (Chief Compliant)

- If a definitive diagnosis was not confirmed, the patient's presenting **signs and symptoms** are coded. "Rule outs" are unacceptable diagnoses in the outpatient setting.

USE OF UNSPECIFIED CODES

ICD-10 diagnosis codes should be directly based on clinical documentation.

- Specific codes reflecting the most appropriate level of certainty known for an encounter should be evaluated first.
- If a definitive diagnosis has not been established by the end of the encounter, it is appropriate to report codes for sign(s) and/or symptom(s) in lieu of a definitive diagnosis.
- When sufficient clinical information is not known or available about a particular health condition to assign a more specific code, coding should comply with the payer guidelines for the use of unspecified codes.

Instances When Unspecified DX Codes Make Sense

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- The patient may be early in the course of evaluation
- The unspecified code may be coming from a provider who is not directly diagnosing the patient's condition
- The clinician seeing the patient may be more of a generalist and not able to define the condition at the level of detail expected by a specialist
- If there is insufficient information to more accurately define a condition, then an unspecified code may be appropriate

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Example of When NOT to Use an Unspecified Code

"Unspecified Codes" have been removed from ICD-10-CM whenever a clinician should be able to identify a more specific diagnosis based on clinical assessment.

EXAMPLE:
Cutaneous Abscess of the Hand

Clinician should be able to identify which hand had the abscess, and therefore, would report using the code that specifies the right or left hand.

L02.511 Cutaneous Abscess Right Hand and

L02.512 Cutaneous Abscess Left Hand

Examples of Increased Specificity

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ABDOMINAL PAIN AND TENDERNESS

When documenting abdominal pain, include the following:

- **Location:** e.g. Generalized, Right upper quadrant, periumbilical, etc.
- **Pain or tenderness type:** e.g. Colic, tenderness, rebound

ICD-10 Code Examples:

- **R10.31 -** Right lower quadrant pain
- **R10.32 -** Left lower quadrant pain
- **R10.33 -** Periumbilical pain
- **R10.84** – Generalized abdominal pain

***** AVOID USING R10.9 – ABDOMINAL PAIN, UNSPECIFIED***

ICD-10-CM Coding Example Asthma

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Asthma

- ✓ Mild intermittent asthma J45.2-
- ✓ Mild persistent asthma J45.3-
- ✓ Moderate persistent asthma J45.4-
- ✓ Severe persistent asthma J45.5-

Documentation suggestions: Triggers of the conditions, Tabacco use, any additional conditions, type of asthma

ICD-10-CM Coding Example Obesity

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Body Mass Index

- Body Mass Index is a STATUS not a diagnosis
  - Z68.-

- Documentation must include the BMI **and** a diagnosis of
  - Morbid (severity) obesity due to excess calories **E66.01**
  - Drug Induces obesity **E66.1**
  - Morbid (severe) obesity with alveolar hypoventilation **E66.2**
  - Obesity **E66.3**

Classes for Obesity: Class 1, Class II, Class III based on BMI

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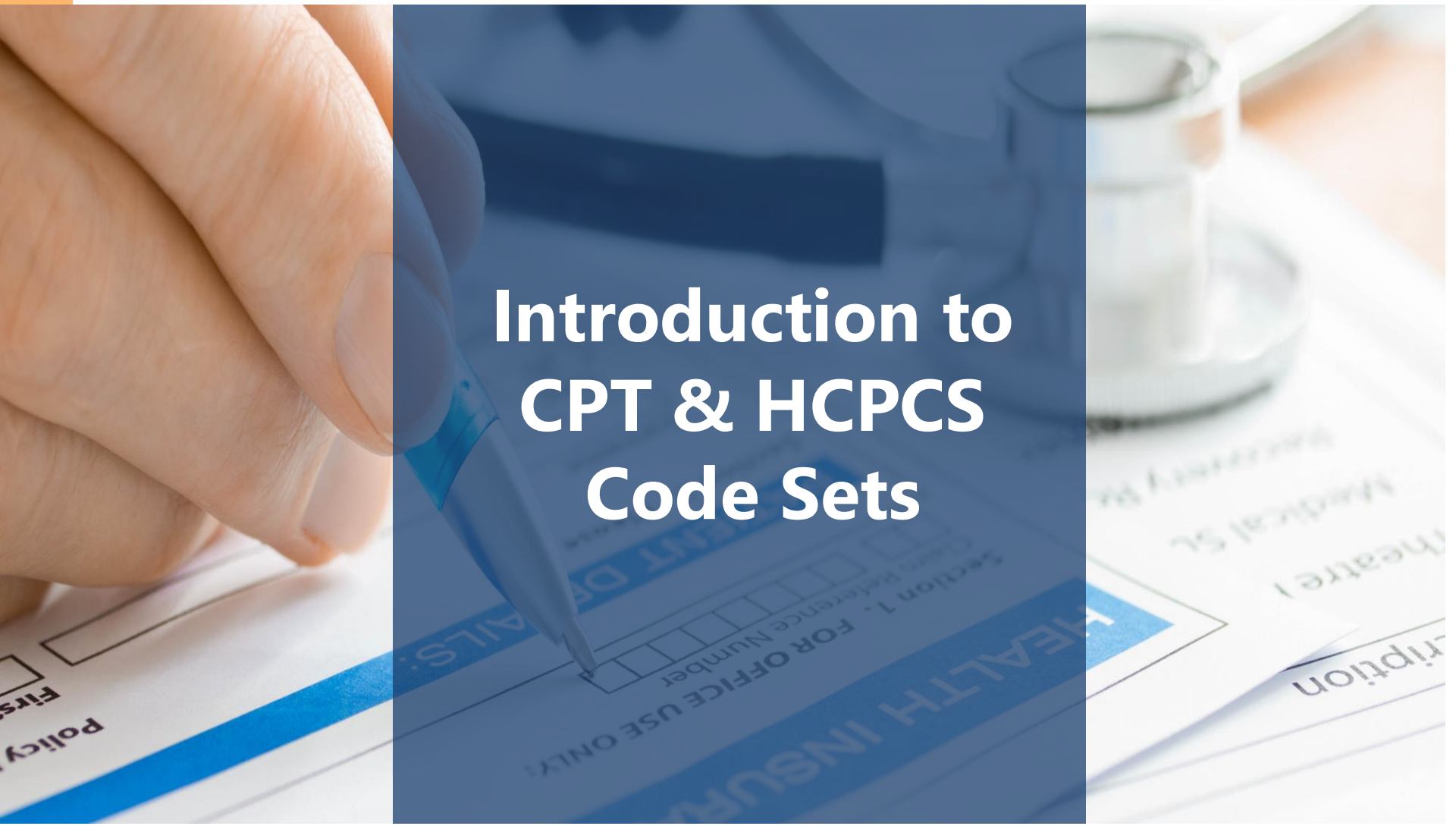

Introduction to CPT & HCPCS Code Sets

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Current Procedural Terminology (CPT)

Current Procedural Terminology (CPT®) codes provide a uniform nomenclature for coding medical procedures and services. Medical CPT codes are critical to streamlining reporting and increasing accuracy and efficiency, as well as for administrative purposes such as claims processing and developing guidelines for medical care review.

-American Medical Association

- Assigned RVUs for Payment
- Assigned a Fee Schedule
- May be "modified"
- Has multiple "categories"

CPT Code Sets

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Evaluation and Management Services		99202 – 99499
Anesthesiology		00100 – 01999, 99100 - 99140
Surgery		10004 - 69990
Radiology (Including Nuclear Medicine and Diagnostic Ultrasound)		70010 - 79999
Pathology and Laboratory		80047 – 89398, 0001U – 0284U
Medicine		90281 - 99607
Category II Codes	Tracking	0001F – 9007F
Category III Codes	Temporary	0042T – 0713T

CPT + Body Systems

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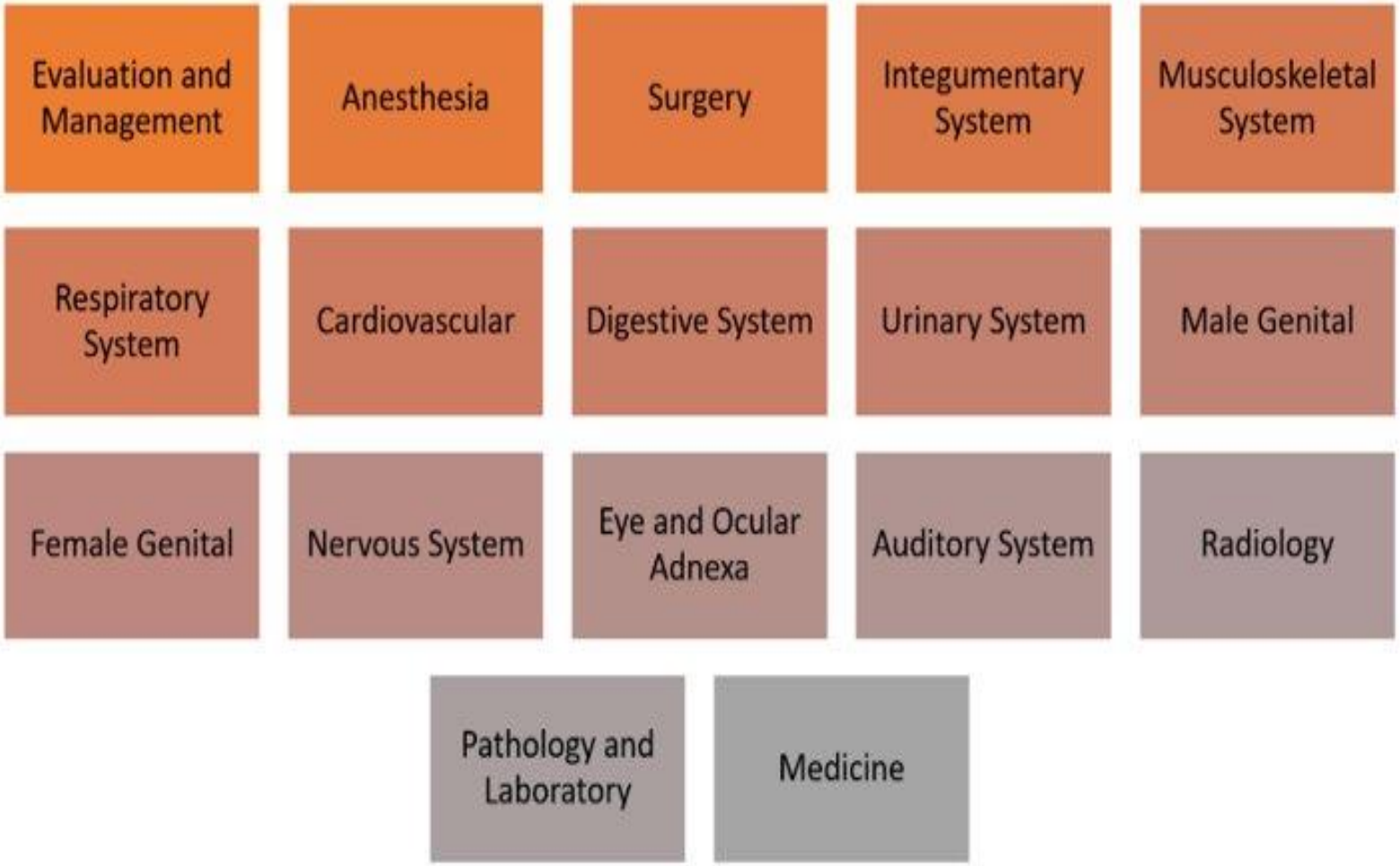

Integration of Anatomy & Physiology

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Anatomy & Physiology

Anatomy – Body Parts

Physiology – Function of Body Parts

Medical Terminology	Meaning
Superior	Above
Inferior	Below
Distal	Farthest from center
Proximal	Nearest to center
Medial	Middle
Lateral	Side
Supine	Face up or Palm up
Prone	Face down or Palm down

Prefix	Meaning	Example
Bi	Two	Bilateral
Ab	Away from	Abduction

Suffix	Meaning	Example
-emia	Blood	Anemia
-opathy	Disease of	Neuropathy

Modifiers as A Code Set

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A modifier gives insurers more information about a claim's procedure or service and often has a financial impact. Omitting or misusing a modifier can cause a claim to be rejected or paid incorrectly. *-AAPC*

24 - Unrelated Evaluation and Management Service by the Same Physician or other qualified Healthcare Professional During a Postoperative Period
25 - Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or other Healthcare Professional on the Same Day of the Procedure or Other Service
26 – Professional Component
33 – Preventive Service
50 – Bilateral Service
51 – Multiple Procedures
52 – Reduced Services
59 – Distinct Procedural Service

Place of Service Codes

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These codes should be used on professional claims to specify the entity where service(s) were rendered. Check with individual payers (e.g., Medicare, Medicaid, other private insurance) for reimbursement policies regarding these codes.

-CMS

01 - Pharmacy
02 - Telehealth
04 - Homeless Shelter
09 - Prison/ Correctional Facility
11 - Office
12 - Home
13 - Assisted Living Facility
15 - Mobile Unit
17 - Walk-in Retail Health Clinic
19 - Off Campus Outpatient Hospital
20 - Urgent Care Facility

21 - Inpatient Hospital
22 - On Campus Outpatient Hospital
23 - Emergency Room Hospital
24 - Ambulatory Surgery Center
31 - SNF
32 - Nursing Facility
34 - Hospice
50 - FQHC
60 - Mass Immunization Center
81 - Independent Laboratory

HCPCS Code Set

Healthcare Common Procedure Coding System (HCPCS) is the,
"Standardized coding system that is separate from CPT used to identify:

- ❑ Products
- ❑ Supplies
- ❑ Services

Medicare and other payers reimburse for these items that are not listed in CPT when used outside of a physicians office. HCPCS Level II codes are used to report and bill for these claims. These items include:

- ❑ Ambulance Services
- ❑ Durable Medical Equipment (DME)
- ❑ Prosthetics
- ❑ Orthotics
- ❑ Supplies (DMEPOS)
- ❑ Drugs

www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/HCPCS_Coding_questions

HCPCS Code Set Examples

Durable Medical Equipment

- E0158 – Leg extensions for walker, per set of 4
  - Leg extensions are considered medically necessary DME for patients 6 feet tall or more

Medical and Surgical Supplies

- A6023 – Collagen dressing, sterile, size more than 48 sq. in., each.

Temporary Procedures/Professional Services

- G2251 – Brief communication technology-based service, e.g. virtual check-in by qualified health care professional who cannot report Evaluation and Management services

Preventive Service

Differences between HCPCS and CPT

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Code Set	Codes Uses	Code Structure	Maintaining Body	Period in Use	Frequency of Updates
HCPCS Level I Current Procedural Terminology (CPT), Fourth Edition	Procedures and services provided by physicians and other allied healthcare professionals	5 numeric characters; some codes with a fifth alpha character	AMA	1966 to present	Yearly major update with quarterly or Jan./July update of certain code ranges
HCPCS Level II Healthcare Common Procedure Coding System (HCPCS)	Drugs, supplies, equipment, nonphysician services and services not represented in CPT®	5 characters, beginning with a letter and followed by 4 numbers	CMS	1983 to present	Quarterly updates

Table Credit: American Academy of Professional Coders

https://aapc.com/resources/medical-coding/hcpcs.aspx#StructureofLevelIIHCPCSCodes

Telehealth Code Sets

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TYPE OF SERVICE	WHAT IS THE SERVICE?	HCPCS/CPT CODE	Patient Relationship with Provider
MEDICARE TELEHEALTH VISITS	A visit with a provider that uses telecommunication systems between a provider and a patient.	Common telehealth services include: • 99201-99215 (Office or other outpatient visits) • G0425–G0427 (Telehealth consultations, emergency department or initial inpatient) • G0406–G0408 (Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs) For a complete list: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes	For new* or established patients. *To the extent the 1135 waiver requires an established relationship, HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency
VIRTUAL CHECK-IN	A brief (5-10 minutes) check in with your practitioner via telephone or other telecommunications device to decide whether an office visit or other service is needed. A remote evaluation of recorded video and/or images submitted by an established patient.	• HCPCS code G2012 • HCPCS code G2010	For established patients.
E-VISITS	A communication between a patient and their provider through an online patient portal.	• 99421 • 99422 • 99423 • G2061 • G2062 • G2063	For established patients.

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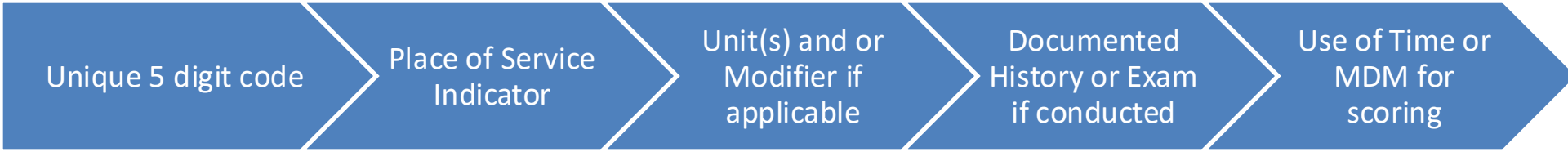
E/M SERVICES

Evaluation & Management Code Sets

Evaluation and management (E/M) coding and billing are crucial to maintaining the efficiency and productivity of a medical practice today. E&M coding involves use of CPT codes ranging from 99202 to 99499. These represent services by a physician (or other health care professional) in which the provider is either evaluating or managing a patient's health. Procedures such as diagnostic tests, radiology, surgeries and other particular therapies are not considered evaluation and management services.

-American Medical Association



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New Patient vs. Established Patient

NEW PATIENT	ESTABLSIHED PATIENT
A patient that has never been seen by any provider in the Practice; or has not been seen in practice within last 3 years.	A patient that has been seen by a provider in the Practice (TIN) within the last 3 years.

Evaluation & Management Abbreviated Code Set

Code Set	Description
• 99202 – 99215	• Office or Other Outpatient Service
• 99221 – 99239	• Hospital In-Pt & Observation Care
• 99242 – 99255	• Consultations
• 99281 – 99288	• Emergency Department Services
• 99358 – 99360	• Prolonged Services
• 99366 - 99368	• Case Management Services

https://www.aapc.com/resources/what-are-e-m-codes

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Chief Complaint

- ✓ **Each** encounter must have a Chief Complaint.
- ✓ The Chief Complaint is a brief statement describing the symptom, problem, condition, physician recommended return, or other reasons for the encounter - usually in the patient's own words.
- ✓ Documenting "follow up" or "Rx refill" is not a sufficient Chief Complaint.
- ✓ Documenting Weight Gain / Weight Loss does not appropriately reflect the complexity of the encounter.

Medical Decision Making (MDM)

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Code	Time	Level of MDM (Based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data to Be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 Below	Risk of Complications and/or Morbidity or Mortality of Patient Management
99242 99252 99221 99231 99282 99202 99212	20 35 40 25 N/A 15-29 10-19	**Straightforward**	**Minimal** • 1 self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**
99243 99253 99221 99231 99283 99203 99213	30 45 40 25 N/A 30-44 20-29	**Low**	**Low** • 2 or more self-limited or minor problems; or • 1 stable, chronic illness; or • 1 acute, uncomplicated illness or injury; or • 1 stable, acute illness; or • 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care	**Limited** *(Must meet the requirements of at least 1 out of 2 categories)* **Category 1: Tests and documents** **Any combination of 2 of the following:** • Review of prior external note(s) from each unique source; • Review of the result(s) of each unique test; • Ordering of each unique test or **Category 2 Assessment requiring an independent historian (s)**	**Low risk of morbidity from additional diagnostic testing or treatment**
99244 99254 99222	40 60 55	**Moderate**	**Moderate** • 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; or • 2 or more stable, chronic illnesses; or • 1 undiagnosed new problem with uncertain prognosis;	**Moderate** *(Must meet the requirements of at least 1 out of 3 categories)* **Category 1: Tests, documents, or independent historian(s)** Any combination of 3 from the following: • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test;	**Moderate risk of morbidity from additional diagnostic testing or treatment** *Examples only:* • Prescription drug management • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors

MDM Continued

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99232 99284 99204 99214	35 N/A 45-59 30-29		or • 1 acute illness with systemic symptoms; or • 1 acute, complicated injury	• Assessment requiring an independent historian or **Category 2: Independent interpretation of tests** • Independent interpretation of a test performed by another physician/other QHP (not separately reported); or **Category 3: Discussion of management or test interpretation** • Discussion of management or test interpretation with external physician/other QHP/appropriate source (not separately reportable)	• Diagnosis or treatment significantly limited by social determinants of health
99245 99255 99223 99233 99285 99205 99215	55 80 75 50 N/A 60-74 40-54	**High**	**High** • 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; or • 1 acute or chronic illness or injury that poses a threat to life or bodily function	**Extensive** *(Must meet the requirements of at least 2 out of 3 categories)* **Category 1: Tests, documents or independent historian(s)** **Any combination of 3 from the following:** • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test*; • Assessment requiring an independent historian(s) or **Category 2: Independent interpretation of tests** • Independent interpretation of a test performed by another physician/other QHP (not reported separately) or Category 3: Discussion of management or test interpretation • Discussion of management or test interpretation with external physician/QHP/appropriate source (not separately reported)	**High risk of morbidity from additional diagnostic testing or treatment** *Examples only:* • Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization or escalation of hospital-level care • Decision not to resuscitate or to de-escalate care because of poor prognosis • Parenteral controlled substances

In Conclusion

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- Remember that the Medical Record is a LEGAL document so avoid fraud, waste and abuse by staying educated on changing guidelines
- Use credible resources such as your EMR and coding manuals to increase Diagnosis specificity
- If you are unfamiliar with the 2021 E/M changes, use our resources to learn more
- Have Provider Document findings:
  - Diagnosis
  - Treatment and plan
  - Update your medication list
  - Update your problem list
  - Sign your notes within a specific time with your credentials

Resources

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud-Abuse-MLN4649244.pdf

https://oig.hhs.gov/reports-and-publications/featured-topics/ihs/training/fraud-waste-and-abuse-for-health-care-providers/content/#/

https://www.cms.gov/medicare/coding-billing/place-of-service-codes/code-sets

https://www.cms.gov/files/zip/list-telehealth-services-calendar-year-2024.zip

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/CERTMedRecDoc-FactSheet-ICN909160.pdf

https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/eval-mgmt-serv-guide-icn006764.pdf

https://www.aapc.com/resources/evaluation-management-coding-changes-2021

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