Your Medical Documentation Matters

Presentation

Objectives

At the conclusion of this presentation, participants will be able to:

• Identify Medicaid medical documentation rules
• Explain that services rendered must be well documented and that documentation lays the foundation for all coding and billing
• Describe the national impact of improper payments

Goals

• The participant will become familiar with Medicaid medical documentation rules
• The participant will discover through a case study the importance of complete and detailed documentation as the foundation for coding, billing, and quality of care for the patient
• The participant will learn how insufficient documentation leads to both poor patient care and to improper payments, which have a negative national impact on Medicaid
Medicaid Is Unique

- States have the flexibility of tailoring their Medicaid programs
- It is the medical professional’s responsibility to know and adhere to all Medicaid rules
- If there are questions, contact your State Medicaid agency (SMA) at http://medicaiddirectors.org/

Progressive Case Study

Meet J.K.
J.K. is:
- 52 years old
- Male
- 265 pounds
- Married

Medical Professionals and Documentation

Documentation is an important aspect of patient care and is used to:
- Coordinate services among medical professionals
- Furnish sufficient services
- Improve patient care
- Comply with regulations
- Support claims billed
- Reduce improper payments
Purpose of Electronic Health Records

The purpose of electronic health records (EHRs) is to improve health care:

- Quality
- Safety
- Efficiency

General Principles of Medical Record Documentation

General principles of documentation include:

- The medical record should be complete and legible
- The documentation of each patient encounter should include the:
  - Reason for the encounter and relevant history, physical examination findings, and prior diagnostic results
  - Assessment, clinical impression, or diagnosis
  - Medical plan of care
  - Date and legible identity of the observer

General Principles of Medical Record Documentation—Continued

Document the:

- Rationale for ordering diagnostic and other ancillary services
- Past and present diagnoses
- Health risk factors
- Patient progress, treatment changes, and response
- Diagnosis and treatment codes reported on the health insurance claim form or billing statement
Emergency Services—Ambulance

J.K. is transported by ambulance to the nearest hospital emergency department (ED). During transport, a brief history was taken, including his:

- Chief complaint (C.C.)
- Vital signs
- Current medications
- Medical ambulance need

Emergency Transportation Documentation—Driver/EMT

At a minimum, document the:

- Patient’s identifying information
- Requester’s name and address
- Date of transport
- Location pickup and time
- Location drop-off and time
- Loaded mileage

Emergency Transportation Documentation—State-Specific

Know your State-specific documentation expectations, such as:

- Pre-Hospital Care Report
- Dispatcher’s log
- Trip ticket
- Ambulance Run Report
- Medical need for the ambulance
Documentation—Lacking

The missing documentation included:

- Medical necessity documentation
- A Physician Certification Statement
- Required signatures

Documentation—Legible

Medicaid medical records should be legible. At a minimum, a medical record should be:

- Written so it can be read
- Written in ink
- Written in clear language
- Written without alterations

Clarity in EHR

- Specific to patient
  - Avoid “cloning,” auto-fill, or key word features
  - Document patient’s description
  - Include clinical notes for visit
- Update patient history and life events
- Check spelling and acronym usage
  - Turn off autocorrect spelling (might change acronyms to words)
  - Clearly separate individual notes with punctuation, spacing, or paragraph returns
Company Oversight

Transportation companies are also responsible for maintaining records, including:

• Provider agreements
• Driver qualifications
• Criminal background checks
• Certification requirements
• Vehicle documentation
• Medical necessity

Emergency Services—Evaluation

History and physical revealed:

• Blood glucose of 260 mg/dL
• 2-centimeter foot ulcer
• Surrounding necrotic tissue extending 2 centimeters
• Foot is red and warm to the touch
• Pinprick test indicates no sensation
• Lacks ankle reflexes

Evaluation and Management Services

• Use 1995 or 1997 guidelines
• The guidelines furnish a systematic approach for diagnosing, treating, and documenting patient care
• Do not intermingle the two sets of guidelines
Evaluation and Management Principles

These principles include:

• Complete and legible record
• Documentation of:
  o Reason for encounter, including,
    • Relevant history
    • Examination findings
    • Prior diagnostic test results
  o Assessment, clinical impression, or diagnosis
  o Plan of care
  o Date and legible identity of observer

Evaluation and Management Principles—Continued

• Rationale for ordering diagnostic and ancillary services
• Availability of past and present diagnoses for providers
• Identification of health risk factors
• Patient’s progress, response to treatment, and any revision of diagnosis
• Support for diagnostic and treatment codes used

Evaluation and Management Coding—Patient Type

• New
• Established
**Evaluation and Management Coding—Setting**

- Office/outpatient
- Hospital inpatient
- Emergency department (ED)
- Nursing facility

**Evaluation and Management Coding—Determining Service Level**

Level of service is made up of three key components:

- History
- Examination
- Medical decision-making

**Key Component—History**

<table>
<thead>
<tr>
<th>TYPE OF HISTORY</th>
<th>CHIEF COMPLAINT</th>
<th>HISTORY OF PRESENT ILLNESS</th>
<th>REVIEW OF SYSTEMS</th>
<th>PAST, FAMILY, AND/OR SOCIAL HISTORY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem Focused</td>
<td>Required</td>
<td>Brief</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Expanded Problem Focused</td>
<td>Required</td>
<td>Brief</td>
<td>Problem Pertinent</td>
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<tr>
<td>Detailed</td>
<td>Required</td>
<td>Extended</td>
<td>Extended</td>
<td>Pertinent</td>
</tr>
<tr>
<td>Comprehensive</td>
<td>Required</td>
<td>Extended</td>
<td>Complete</td>
<td>Complete</td>
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</tbody>
</table>
### Key Component—Examination

<table>
<thead>
<tr>
<th>TYPE OF EXAMINATION</th>
<th>DESCRIPTION</th>
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</thead>
<tbody>
<tr>
<td>Problem Focused</td>
<td>Include performance and documentation of one to five elements identified by a bullet, whether in a box with a shaded or unshaded border.</td>
</tr>
<tr>
<td>Expanded Problem Focused</td>
<td>Include performance and documentation of at least six elements identified by a bullet, whether in a box with a shaded or unshaded border.</td>
</tr>
<tr>
<td>Detailed</td>
<td>Examinations other than the eye and psychiatric examinations should include performance and documentation of at least twelve elements identified by a bullet, whether in a box with a shaded or unshaded border. Eye and psychiatric examinations include the performance and documentation of at least nine elements identified by a bullet, whether in a box with a shaded or unshaded border.</td>
</tr>
<tr>
<td>Comprehensive</td>
<td>Include performance of all elements identified by a bullet, whether in a shaded or unshaded box. Documentation of every element in each box with a shaded border and at least one element in a box with an unshaded border is expected.</td>
</tr>
</tbody>
</table>

### Key Component—Medical Decision-Making

<table>
<thead>
<tr>
<th>TYPE OF DECISION MAKING</th>
<th>NUMBER OF DIAGNOSSES OR MANAGEMENT OPTIONS</th>
<th>AMOUNT AND/OR COMPLEXITY OF DATA TO BE REVIEWED</th>
<th>RISK OF SIGNIFICANT COMPLICATIONS, MORBIDITY, AND/OR MORTALITY</th>
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<tr>
<td>Straightforward</td>
<td>Minimal</td>
<td>Minimal or None</td>
<td>Minimal</td>
</tr>
<tr>
<td>Low Complexity</td>
<td>Limited</td>
<td>Limited</td>
<td>Low</td>
</tr>
<tr>
<td>Moderate Complexity</td>
<td>Multiple</td>
<td>Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>High Complexity</td>
<td>Extensive</td>
<td>Extensive</td>
<td>High</td>
</tr>
</tbody>
</table>

### Orthopedic Consult Report Documentation

Day of consult:
- C.C.: Swollen painful right foot and leg
- HPI: Extended
- ROS: Extended
- PFSH: Complete
- History: Complete
Consult Decision

Extended Review of Systems

Comprehensive History

Detailed Examination

Consult Decision

Justify the Codes Billed

Support the code billed or return the payment.

Coding

CPT: 99222
Modifier: 57
Operation (OP) Notes

- Pre-op diagnosis: Osteomyelitis, right foot with abscess
- Post-op diagnosis: Osteomyelitis, right foot with abscess
- Procedure: Right Below Knee Amputation
- Anesthesia: General

Documented Surgical Codes

- ICD-10-CM M86.19
- CPT: 27880

J.K. Post-Surgery

Documentation and coding
- SOAP Notes
  - Subjective
  - Objective
  - Assessment
  - Plan
- Postoperative days
- Code—Global
Global Billing

- Hospital inpatient—4 days
- Global surgery—no additional charge
- Day of discharge—cannot be billed

Hospital Services—Discharge Summary

A discharge summary is a Medicaid requirement and typically includes:
- Patient outcome after hospitalization
- Case disposition
- Follow-up care

Rehabilitation

Rehabilitation (rehab) is paid for by Medicaid:
- In an acute-care setting
- When it is medically necessary
- When it is to treat an acute condition or exacerbation
Physical Therapy Treatment Plan

A treatment plan is required and should include:

- Beneficiary’s name
- Beneficiary’s Medicaid identifier
- Diagnosis(es)
- Date of onset/date of the acute exacerbation
- Surgery performed
- Date of surgery
- Functional status before PT started and after PT is completed
- Frequency and duration of treatment
- Modalities
- Documentation of any ulcers, including the location, size, and depth

Physical Therapy Documentation

PT documentation includes:

- A treatment plan
- Ordering physician’s signature
- Daily notes
- Date and PT signature
- Medical information that is readily available in the record
- Justification for billing services

Discharge

Follow-up appointments with:

- Surgeon
- Durable medical equipment (DME) medical professional
- Mental health practitioner
Durable Medical Equipment Documentation

Keep your ducks in a row
• Check member Medicaid eligibility monthly
• File medical necessity documents
  o Prescription
    • Diagnosis
    • Prognosis
    • Length of time needed
    • Signed
    • Dated

Durable Medical Equipment Documentation—Continued

• Prior authorization
  o Prescription or written order
  o Enough medical information for an independent source to make a determination the item(s) is reasonable and necessary
• Proof of the approved authorization

Durable Medical Equipment Documentation—Continued

• Evaluation
• Fitting
• Repairs—90 days
• Adjustments—90 days
Billing Durable Medical Equipment

- Electronic—Form ASCX12N:837
- Paper claim—CMS-1500
- State-specific information may be required

Mental Health Services

J.K.’s depression shows

Diagnostic and Statistical Manual for Mental Disorders

- Published by the American Psychiatric Association
- Covers mental health disorders for children and adults
- The manual lists:
  - Known causes
  - Statistics
  - Prognosis
  - Evidence-based treatment approaches
Mental Health Benefits

Mental health services must be:
1. Medically necessary
2. The least restrictive
3. Documented, with records retained

Client Assistance Program

The client assistance program allows for:
• Five visits
• No prior authorization
• No Axis I diagnosis
• No formal treatment plan

Solution-Focused Brief Therapy

Solution-focused brief therapy (SFBT) includes:
• Holding an initial meeting
• Focusing on the present and future
• Establishing goals
• Determining steps to attain the goal
Billing Mental Health Services

- Document each session
- Document progress
- Sign and date notes
- Submit claim within 60 days

Discharge

J.K. is discharged from all services

Medicaid Costs

- Joint Federal-State costs for 2014 were $476 billion
- Medicaid spending has grown by 450 percent in the last 20 years
- Medical professionals can make a difference
Improper Payments

Claims made for:
• Treatments or services not covered by program rules
• Services not medically necessary
• Services billed but never provided

Medical Professional Guidelines

• Develop a compliance program
  https://oig.hhs.gov/compliance/compliance-guidance/index.asp
• Perform self-audits
• Check for exclusions

Basic Self-Audit Rules

1. Develop a medical record documentation policy
2. Use an audit tool
3. Select charts for review
4. Perform the audit
5. Use the audit results
Screen for exclusions because:

- Excluded employees cannot participate in Federal health care programs
- Federal health care programs cannot pay for any items or services that are furnished, ordered, or prescribed by an excluded individual
- “Furnished” includes items or services provided or supplied, directly or indirectly

https://oig.hhs.gov/exclusions/index.asp
https://www.sam.gov/index.html/#1
https://oig.hhs.gov/exclusions/tips.asp

Report It!

- SMA and Medicaid Fraud Control Unit (MFCU)
- HHS-OIG
  ATTN: Hotline
  P.O. Box 23489 Washington, D.C. 20026
  Phone: 1-800-447-8477 (1-800-HHS-TIPS)
  TTY: 1-800-377-4950
  Fax: 1-800-223-8164
  Email: HHSTips@oig.hhs.gov
  Website: https://forms.oig.hhs.gov/hotlineoperations/
Conclusion

Documentation done well:
• Justifies billed claims
• Improves patient care and safety
• Protects the medical professional
• Follows Medicaid rules and regulations
• Reduces improper payments

Questions

Please direct questions or requests to: MedicaidProviderEducation@cms.hhs.gov

To see the electronic version of this presentation and the other products included in the Documentation Matters Toolkit, visit the Medicaid Program Integrity Education page at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html on the CMS website.

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