Basic Medical Record Documentation

Presented by
Cahaba Government Benefit Administrators®, LLC
Provider Outreach and Education
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Topics

- The Medical Review Program
  - Data Analysis

- Comprehensive Error Rate Testing (CERT)
  - CERT Examples

- Medical Record Documentation
  - CMS Signature Requirements

- CMS and Cahaba GBA Resources

Preventing Improper Payments

Centers for Medicare and Medicaid Services (CMS)
- Protect the Medicare Trust Fund
- Identify inappropriate payments
- Take corrective actions

  - Improper Payments Errors
    - Documentation and administrative
    - Authentication and medical necessity
    - Verification errors

Payment Accuracy:  [http://www.paymentaccuracy.gov/about-improper-payments](http://www.paymentaccuracy.gov/about-improper-payments)
The Medical Review Program

- Prevent improper payments in the Medicare FFS program
- May require evaluation of medical records and related documents to determine whether Medicare claims were billed in compliance with coverage, coding, payment, and billing policies

Program Integrity Manual (PIM) Publication 100-08 - Medical Review Program:
Medical Review Program

Data Driven Goals

• Identify vulnerabilities
• Identify questionable billing patterns
• Prevent and/or address provider errors
• Reduce paid claims error rate
• Publish Local Coverage Determinations (LCD)

Program Integrity Manual - Pub. 100-08 - Medical Review Program
Medical Review Data

Comparative Billing Report
Dates of Service: January 2012 - June 2012

<table>
<thead>
<tr>
<th>Code</th>
<th>Provider Specific</th>
<th>Specialty Peers</th>
</tr>
</thead>
<tbody>
<tr>
<td>99221</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td>99222</td>
<td>4.32%</td>
<td>41.64%</td>
</tr>
<tr>
<td>99223</td>
<td>100.00%</td>
<td>54.04%</td>
</tr>
</tbody>
</table>

Comparative Billing Reports (CBR)

Cahaba GBA CBRs
- Provider specific request
- Compare specific billing practice
- Educational tool
- CBR Required Information:
  - Provider Transaction Access Number (PTAN) or Provider Identifying Number (PIN)
  - Report fee is $20.00 per report
  - Separate required fee for multiple provider reports

CMS Pub 100-08, Medicare Program Integrity Manual, Chapter 3, Section 3.11.1.6
## Coverage Determinations

- National Coverage Determinations (NCDs)
  - CMS developed

- Local Coverage Determinations (LCDs)
  - Contractor developed

- Refer to specific coverage determinations for documentation requirements

Cahaba GBA Coverage link: [https://www.cahabagba.com/part-b/medical-review/](https://www.cahabagba.com/part-b/medical-review/)

### LCD "General Information" section

1. Specific LCD Documentation Requirements

2. LCD Signature Statement
   - Documentation must support CMS ‘signature requirements’ as described in the Medicare Program Integrity Manual (Publication 100-08) Chapter 3, Section 3.3.2.4)

Medicare Program Integrity Manual (Publication 100-08) Chapter 3, Section 3.3.2.4
Comprehensive Error Rate Testing

- Measures Improper Payments
- CERT Documentation
  - Request and receive provider medical records
- CERT Review
  - Review selected claims and associated medical records

Nov. 2012 - Part B CERT Findings
Jan 1, 2011 - Dec. 31, 2011

- Insufficient Documentation: 3%
- Incorrect Coding: 41%
- Medical Necessity: 51%

November 2012 CERT Error Feedback article: Part B Educational Tool
http://www.cahabagba.com/part-b/education/comprehensive-error-rate-testing-cert/
## Comprehensive Error Rate Testing

<table>
<thead>
<tr>
<th>Type of CERT Error</th>
<th>Error Identified by CERT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insufficient Documentation</td>
<td>• Submitted notes containing the medical necessity for the tests, but <strong>missing the treating provider’s intent to order the billed lab tests</strong>.</td>
</tr>
<tr>
<td></td>
<td>• Missing physician orders for diagnostic lab tests. Missing clinical documentation to support diagnosis and complaints prompting physician to order diagnostic tests.</td>
</tr>
<tr>
<td></td>
<td>• Missing physician order and clinical documentation to support diagnosis prompting physician to order urine drug screen. Received unsigned lab requisition and printed test results.</td>
</tr>
<tr>
<td></td>
<td>• Submitted progress note that supports medical necessity, but <strong>missing is the valid order for the TB test</strong>.</td>
</tr>
<tr>
<td>Pathology and Laboratory</td>
<td></td>
</tr>
<tr>
<td>Range of Lab Codes</td>
<td></td>
</tr>
<tr>
<td>Orders/Intent</td>
<td></td>
</tr>
<tr>
<td>Reasonable and Necessary</td>
<td></td>
</tr>
<tr>
<td>August 2013</td>
<td></td>
</tr>
</tbody>
</table>

## Comprehensive Error Rate Testing

<table>
<thead>
<tr>
<th>Type of CERT Error</th>
<th>Error Identified by CERT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insufficient Documentation</td>
<td>• Incorrectly coded. Billed 99291 (Critical Care, first 30-74 minutes).</td>
</tr>
<tr>
<td></td>
<td>• Submitted ED note does not constitute critical care even though time spent was recorded as 30 minutes, but supports care provided for a beneficiary with a stable condition in Emergency Department setting, complaint of SOB and plan to admit the patient.</td>
</tr>
<tr>
<td></td>
<td>• Documentation supports recode to 99284 (ER visit) with</td>
</tr>
<tr>
<td></td>
<td>• Comprehensive History</td>
</tr>
<tr>
<td></td>
<td>• Comprehensive Exam</td>
</tr>
<tr>
<td></td>
<td>• Medical Decision Making of Moderate Complexity</td>
</tr>
<tr>
<td>Critical Care Services</td>
<td></td>
</tr>
<tr>
<td>Medical Necessity</td>
<td></td>
</tr>
<tr>
<td>August 2013</td>
<td></td>
</tr>
</tbody>
</table>
CERT Task Force

Watch for CERT Education Opportunities!

- Partnership that collaborate with providers to assist in reducing CERT error rate and costly claims
- Focuses on four national “hot topics” each year
- Team will publish articles that contain scenarios with recommendations in an effort to reduce specific errors

Article: Introducing the CERT A/B Task Force

Disclaimer: Comprehensive Error Rate Testing (CERT) Part A and Part B (A/B) Contractor Task Force is independent from the Centers for Medicare & Medicaid Services (CMS) CERT team and CERT contractors, which are responsible for calculation of the Medicare fee-for-service improper payment rate.

Importance of Medical Record Documentation
The Medical Record

- Chronological record of patient care
- Records pertinent facts, findings, and observations about a patient’s health history, including past and present illnesses, treatments, examinations, tests, and outcomes
- Documents communication and continuity of care among physicians/healthcare professionals
- May serve as legal document to verify care was provided
- Auditing agencies may verify supporting documentation of services provided

Documentation Guidelines for Evaluation and Management (E/M) Services

Documentation Requirements

“If It Is Not Documented, It’s Not Done”

- Complete and legible record
- Documentation for each encounter should include:
  - Reason for the encounter, relevant history, exam and prior diagnostic test results; reports if applicable;
  - Assessment, clinical impression;
  - Plan for care; and
  - Date and legible identity of the provider; signature required;
  (Program Integrity Manual Pub 100-08, Chapter 3, Section 3.3.2.4)
- Rationale for ordering diagnostic & other ancillary services should be documented or easily inferred;
Documentation Requirements

“If It Is Not Documented, It’s Not Done”

- Past & present diagnoses should be accessible to the treating and/or consulting physician;
- Identify health risk factors;
- Patient’s progress, response to treatment, changes in treatment or revisions in diagnoses should be documented; and
- Document any revisions to the plan of treatment
- Services billed should be supported by medical record documentation; code correctly

The medical record must contain information such as notes, documentation, records, reports, recordings, test results, assessments, etc., to:

- Justify admission;
- Justify continued hospitalization;
- Support the diagnosis;
- Describe the patient’s progress;
- Describe the patient’s response to medications; and
- Describe the patient’s response to services such as interventions, care, treatments, etc.

All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures.

State Operations Manual - Appendix A - Regulations and Interpretive Guidelines for Hospitals - §482.24(c) – §482.24(c)(1)
Standard: Content of Record
Guidelines: Scribed Services

“If It Is Not Documented, It’s Not Done”

- Physician deliver service and create record
- Scribe services conducted in an office or a facility
  - Scribe documents physician’s dictation and/or activities during patient visit
  - Non-Physician Practitioner (NPP)
  - Nurse or other ancillary personnel allowed by physician
- Scribe does not act independently
  - Evaluation and Management (E&M) services, surgical, other encounters
- Qualifications of each person documented
- Records signed and dated by physician and scribe

Scribed Services

“If It Is Not Documented, It’s Not Done”

Who performed the service?
- Physician co-signs the medical record note
  - Example: I, Dr. John Doe, personally performed the services described in this documentation, as scribed by Jane Smith, RN, in my presence, and it is both accurate and complete.

Who recorded the service?
- Medical record entry notes name of “acting scribe for the physician.”
  - Example: I, Jane Smith, RN am scribing for, and in the presence of, Dr. John Doe.
Medical Review - Cloned Electronic Documentation

- Medical necessity of **current services must** be documented
- Document reasonable and medically necessary services
  - **Ensure documentation** of changes and or differences
    - History of Present Illness
    - Review of System and
    - Physical Examination
  - Providers **must sign** their records

Electronic Submission of Medical Records (esMD)

- Cahaba accepts electronic submissions of medical documentation
  - Optional process
  - Faster response time = faster claim cycle time
    - Medical record confirmation = 10 -15 days
    - Standard review timeframes apply
## Signature Requirements

**Change Request (CR) 6698:**

Signature Requirements for Medical Review Purposes

For medical review purposes, Medicare requires that services provided/ordered be authenticated by the author

- Hand written (legible)
- Electronic signature

**Stamp signatures are not acceptable** - new exception

- Change Request 8219 - Use of Rubber Stamp
- The Rehabilitation Act of 1973
- Effective June 18, 2013

## Electronic Health Record (EHR) Signatures

Not an all inclusive list; EHR templates vary

- Examples of acceptable EHR signatures; e-signature documentation may state:
  - Electronically signed and has a typed signature
  - Digitally signed (Physician Name)
  - Dictated by/transcribed by (must be signed or initialed by the physician)
  - Authenticated by (Physician Name)
  - Generated by (Physician Name)
  - Electronically authenticated by (Physician Name)
  - Electronically approved by (Physician Name)
  - Electronically authorized by (Physician Name)
Signature Log

- A signature log lists the typed or printed name of the author associated with initials or an illegible signature
- The signature log might be included on the actual page where the initials or illegible signature are used or might be a separate document
- Reviewers may encourage providers to list their credentials in the log
- However, reviewers shall not deny a claim for a signature log that is missing credentials
- Reviewers shall consider all submitted signature logs regardless of the date they were created

Change Request 6698

Signature Attestation Statement

- An attestation statement must be signed and dated by the author of the medical record entry
- An attestation statement must contain sufficient information to identify the beneficiary
- An attestation statement must have documentation that is associated with the medical record entries and the author of record in question
- In cases where two individuals are in the same group, one may not sign for the other in medical record entries or attestation statements
- Reviewers will consider all attestations that meet the guidelines regardless of the date the attestation was created, except in those cases where the regulations or policy indicate that a signature must be in place prior to a given event or a given date

Change Request 6698
Documentation Reminders and Recommendations

Critical Care Services

Critical Care (CPT 99291 - first 30 – 74 minutes)

- Documentation must support the critical care E&M service

- Document medical necessity of services with the total time the physician and/or hospital staff were engaged in active face-to-face critical care of a critically ill or critically injured patient

- Critical care services/the patient’s condition warranted the type and amount of services provided

Part B Critical Care CPT 99291 Widespread Prepayment Targeted Review Results
Ambulance Services

Thoroughly complete the trip report

- Document concise supporting narrative with conditions codes, if applicable
- Document reasonable and medically necessary services
- Obtain required signatures

Medicare requires the signature of the beneficiary, or that of his or her representative, for both the purpose of accepting assignment and submitting a claim to Medicare. If the beneficiary is unable to sign, guidelines specify the individuals that may sign the claim form on behalf of the beneficiary.

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CMS Beneficiary Signature Requirements

- Medicare Benefit Policy Manual - Chapter 10:20.1.2
- Who may sign (not all inclusive list)
  - Legal guardian
  - On behalf of beneficiary, a relative or other person
    - Manage the patient affairs
    - Receives beneficiary’s governmental benefits
    - Arrange treatments
  - Agency representative or institution that did not furnish the services, but furnished care
Ambulance Services

Trip record to include:

• Detailed statement of the condition necessitating the ambulance
• Statement if patient was admitted as an inpatient
• Point of pick-up (identify place and complete address)
• Number of loaded miles/cost per mile/mileage charge
• Minimal or base charge and charge for special items or services with an explanation
• Rationale for condition (bed confined if applicable)
• Any further documentation that supports the medical necessity of ambulance transport (e.g., emergency room report)
• Hospital discharge/transfer summary, if applicable

Ambulance Review Results

CERT Special Project: HCPCS A0427

Part B Widespread Targeted Review Results for Ambulance Emergency Transport

• Error rates:
  o Alabama = 63%
  o Georgia = 61%
  o Tennessee = 64%

• Prepayment widespread targeted review will continue for identified errors:
  o Lack of a beneficiary acknowledgement form
  o Documentation did not support medical necessity for ambulance transport
  o Billed date of service not included in the medical record
  o Medical record documentation not submitted timely

Part B Widespread Targeted Review Results for Ambulance Emergency Transport- HCPCS A0427
Outpatient Therapy Services

Check medical record documentation:

- Create a complete plan of care, making certain to include your signature, professional identification (e.g., PT, OTR/L), and date the plan was established;

- Document when the plan of care is modified, including how it has been modified and why the previous goals were not met or could not be met;

- Confirm the plan of care is certified (recertified when appropriate) with physician/NPP signature and date; and

- Clearly document, in minutes, the total treatment time for the timed codes and the total treatment time (including timed and untimed codes) in the patient’s record.

Fact Sheet: Outpatient Rehabilitation Therapy Services: Complying with Documentation Requirements

Appeals Process

- Five Levels of Appeals
  - Redetermination
  - Reconsideration
  - Administrative Law Judge (ALJ) Hearing
  - Departmental Appeals Board (DAB) Review
  - Federal District Court Review
    - Each level must be completed before proceeding to the next level of appeal

Appeal to Cahaba GBA: https://www.cahabagba.com/part_b/claims/appeals.htm
Summation

CMS Regulations and Guidance
- Review and apply coverage determinations, signature requirements
- Develop compliance guidelines/conduct self audits
  - Office of Inspector General (OIG) Compliance Guidance
  - Also refer to “Compliance Guidance 101 Education”
- Documentation: accurate, supports reasonable and medically necessary services
- Ensure documentation of physician’s verified order/plan or documented intent to order diagnostic services
- Legible handwriting, correct coding
- Include procedure reports/results
- Submit requested medical records timely
- Ambulance providers, review and apply specific CMS regulations

Medical Record Documentation

MLN Matters® Number: SE1237
Importance of Preparing/Maintaining Legible Medical Records

- **General Principles of Medical Record Documentation - Be Aware**
  - Medical records should be complete and legible; and
  - Medical records should include provider legible identity and date of service
- **Amendments, Corrections and Delayed Entries in Medical Documentation**
  - Documents containing amendments, corrections, or delayed entries must employ acceptable recordkeeping principles
- **Medicare Signature Requirements**
  - Handwritten or electronic signature

MLN Matters® Number: SE1237 Importance of Preparing/Maintaining Legible Medical Records
Medical Record Documentation

Change Request 8033: Progress Notes and Forms
Effective: 12-10-12, Implementation: 03-21-13

Defines
- Progress Notes
- Progress Note Template
- Licensed/Certified Medical Professional (LCMP)

CMS encourages
“If template are used, select templates that allow full and complete collection of information to demonstrate that applicable coverage and coding criteria are met”


Medical Record Documentation

Change Request 8105: Amendments, Corrections and Delayed Entries
Effective: 01-08-13

Recordkeeping Principles
- Clearly and permanently identify any amendment, correction or delayed entry
- Clearly indicate the date and author of any amendment, correction or delayed entry
- No deletion; clearly identify all original content
  - Paper Medical Records
    - Single line strike through (sign and date)
  - Electronic Health Records
    - Distinctly identify changes
    - Date and sign

Medical Record Documentation

Change Request 8205: Minor PIM Changes - Chapter 1
Effective Date: 04-01-13

- Provider self-audits
- The Office of Inspector General (OIG) Compliance Program Guidelines
  - Guidance on establishing compliance programs

Program Integrity Manual Pub. 100 - B: Chapter 1, Section 1.3.9:

CMS Certificate Billing Education

- Medicare Web-based Training Billing Certificate Program
  - Learn about the Medicare Program
  - Special focus on Medicare billing
  - Self-paced course
  - Specifics for your provider type
- Earn Billing Certificate
  - Successfully complete required courses
  - Complete required readings, and
  - Achieve 75 % or higher score on post-assessment

Part B Medicare Billing Certificate Program, click on “Web-Based Training Modules”
Resources


Cahaba GBA Part B CERT Error Summaries: http://www.cahabagba.com/part-b/education/comprehensive-error-rate-testing-cert/

State Operations Manual - Appendix A - Regulations and Interpretive Guidelines for Hospitals - §482.24(c) - §482.24(c)(1) Standard: Content of Record

MLN9 Documentation Guidelines for Evaluation and Management (E/M) Services:

Electronic Submission of Medical Records (esMD): Providers have the option to submit medical records electronically

Electronic Health Record Incentive Programs Supporting Documentation for Audits – see What's News article:

MLN Connects™ - Continuing Education Credit – Many professional organizations offer continuing education credits for participation in education through the CMS MLN National Provider Calls (NPC) program:

Medicare Learning Network (MLN) - Association Approval for Web-based Training Credits:

Ambulance Resources

Local Coverage Determinations: Search for Transportation Services - Ambulance

CMS Ambulance Service Center:
http://www.cms.gov/Center/Provider-Type/Ambulances-Services-Center.html?redirect=center/ambulance.asp

- Medicare Benefit Policy Manual; Chapter 10 - Ambulance Services
  - Section 10.2 - Necessity and Reasonableness
  - Section 10.3.4 - Documentation Requirements
  - Section 10.3 - Destination
  - Section 30.1 - Categories of Ambulance Services

- Medicare Claims Processing Manual; Chapter 15 - Ambulance Services
  - Section 20.1 – Fee Schedule
  - Section 30 – General Billing Guidelines
    - Section 20.2 – Mileage
    - Section 20.5 – Documentation
  - Section 30 – General Billing Guidelines

Electronic Code of Federal Regulations - § 424.36 Ambulance Services – Beneficiary Signature Requirements:
http://www.ecfr.gov/cgi-bin/ECFR?page=browse

CMS Medicare Learning Network® (MLN) web-based training courses acceptable for Ambulance services CEUs:
Take Our Survey

We'd welcome your feedback!

Thank you for visiting our website. You have been selected to participate in a brief customer satisfaction survey to let us know how we can improve your experience.

The survey is designed to measure your entire experience, please look for it at the conclusion of your visit.

This survey is conducted by an independent company ForeSee, on behalf of the site you are visiting.

No, thanks
Yes, I'll give feedback

Provider Contact Center
Alabama, Georgia and Tennessee Providers: 1-877-567-7271
Thanks for Your Attendance!

Please complete the electronic evaluation at the conclusion of the webinar

OR

Submit your evaluation by using the following direct link provided by email:
http://listmgr.cahabagba.com/subscribe/survey?f=1535