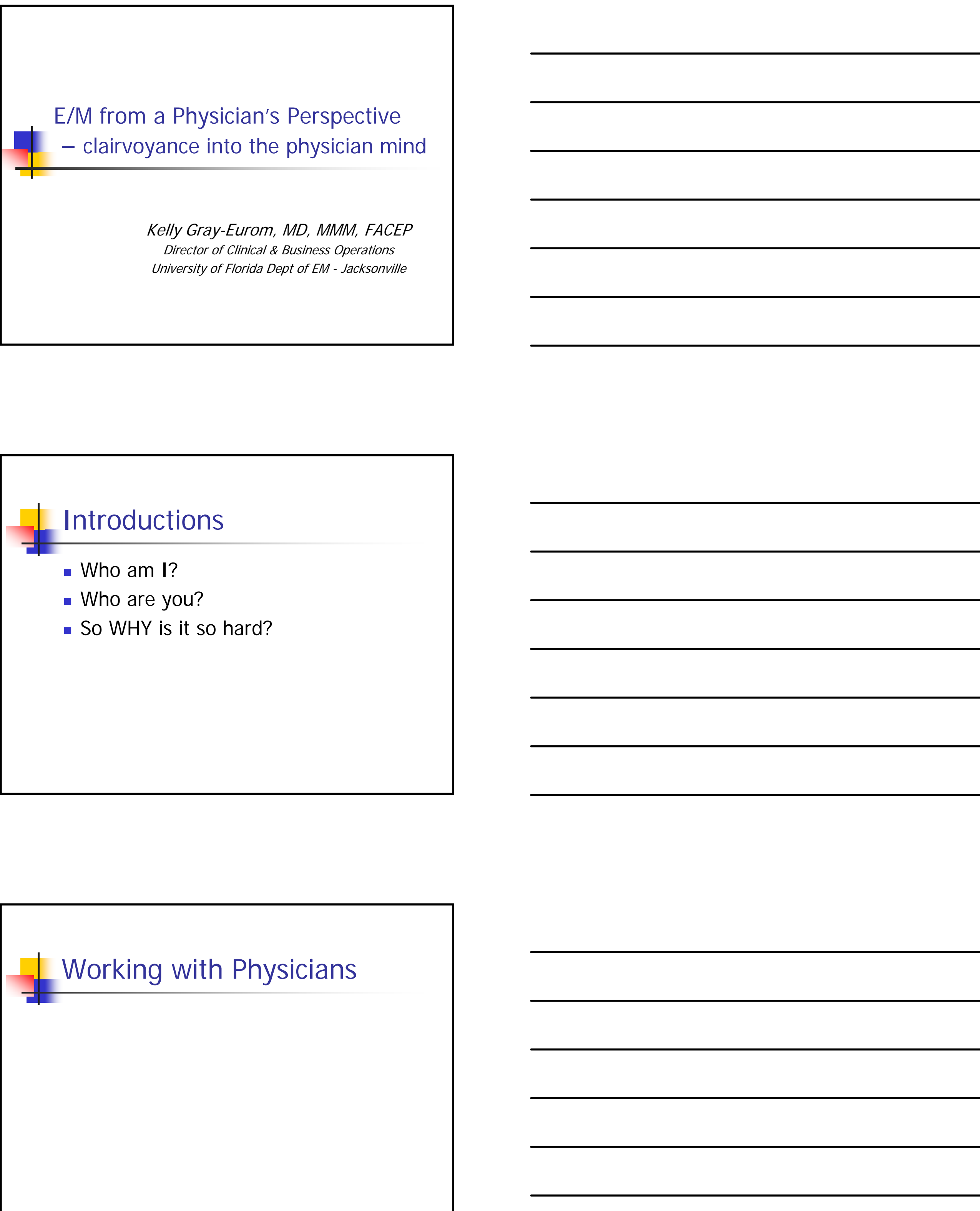
E/M from a Physician's Perspective
– clairvoyance into the physician mind
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Director of Clinical & Business Operations
University of Florida Dept of EM - Jacksonville
Introductions
Who am I?
Who are you?
So WHY is it so hard?
Working with Physicians

Goals

- Insight into the physician view of the coding process;
- Review the physician / coder interactions;
- Discuss potential solutions to overcoming barriers in physician coding comprehension.

Overview

- Traditional Teaching
  - Chart
  - Procedures
  - Diagnoses
- System of Work
- Cloning
- ICD-10
- Remediation

Overview

- Standard Teaching
  - Chart
  - Procedures
  - Diagnoses
- System of Work
- Cloning
- ICD-10
- Remediation

And Please

- Complete the Evaluation…
    - Thank you

RBRVS

- Prior to 1992 – fee for service
- Health Care Financing Administration stepped in –
- Created the Resource Based Relative Value Scale (RBRVS)

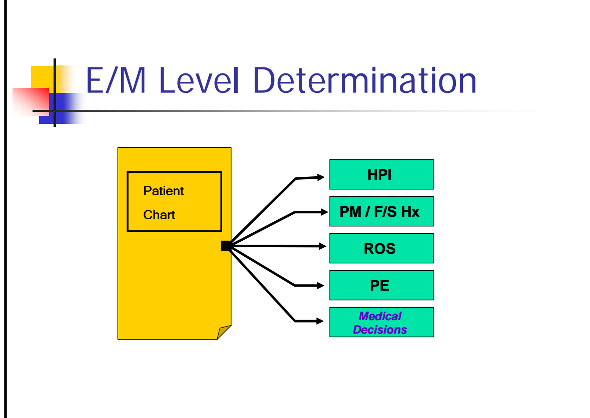
RBRVS

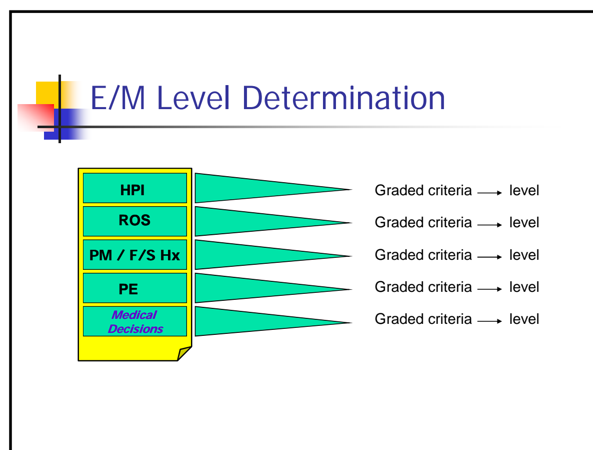
- Defined guidelines for reimbursement
- Based on effort, expertise, complexity, risk
- Same for all specialties

RBRVS

- No longer get paid for what you do
- You get paid for what you document
  - very complex system for revenue generation
  - down-coding due to poor documentation
  - loss of legitimate revenue

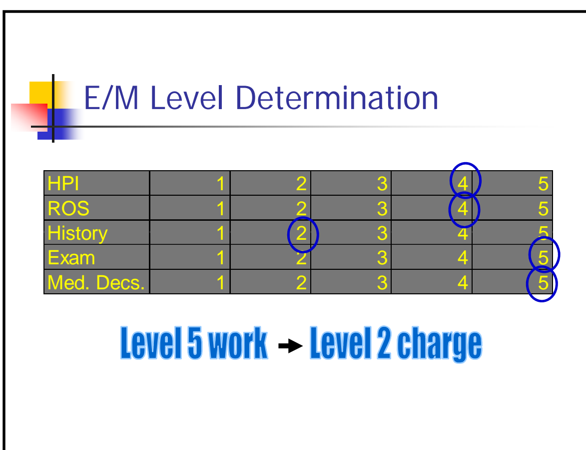
E/M Level Determination



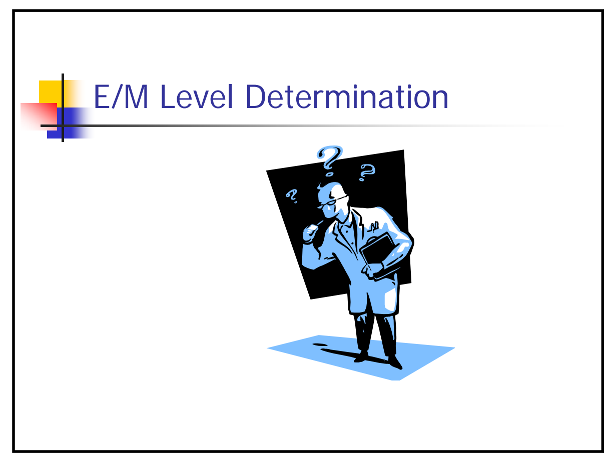


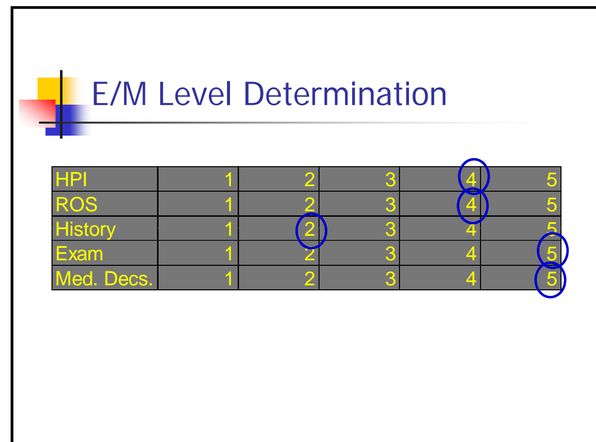
E/M Level Determination

- Seemingly small omissions result in large revenue losses…



HPI	1	2	3	4	5
ROS	1	2	3	4	5
History	1	2	3	4	5
Exam	1	2	3	4	5
Med. Decs.	1	2	3	4	5





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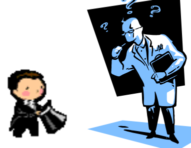
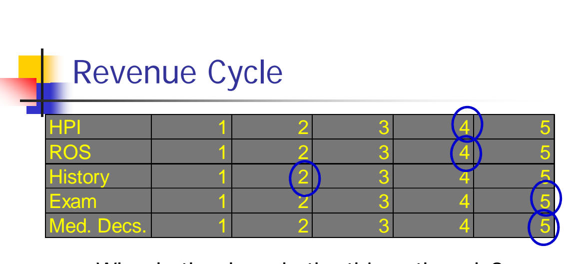
Revenue Cycle

- If you never charge for it, you have no hopes of collecting it…



Revenue Cycle



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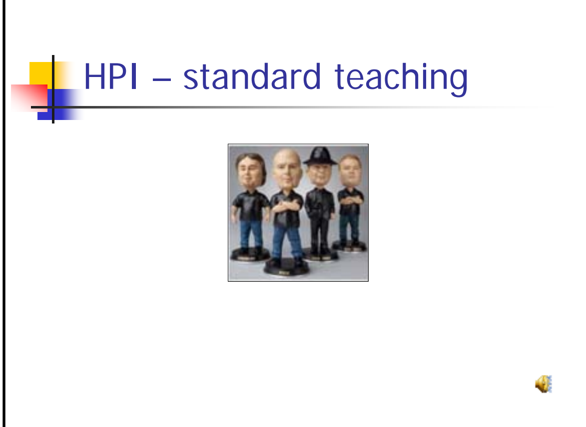
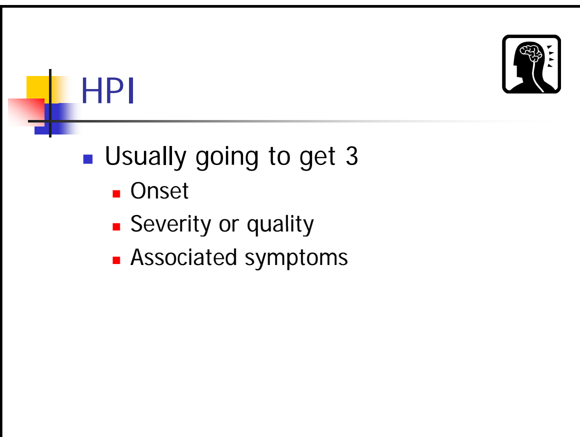
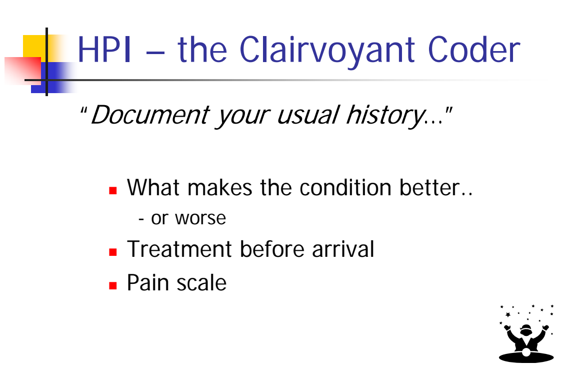
- Why do the docs do the things they do?
- Can you do anything to make it better?

HPI – standard teaching

- "You need to include at least 1 in 4 of the 8 categories to bill a level 5…."
  - Location
  - Severity
  - Quality
  - Duration
  - Timing
  - Context
  - Modifying Factors
  - Associated symptoms


HPI – standard teaching


HPI
Usually going to get 3
Onset
Severity or quality
Associated symptoms


HPI – the Clairvoyant Coder
"Document your usual history…"
What makes the condition better..
- or worse
Treatment before arrival
Pain scale

HPI – the Clairvoyant Coder

"If the history is not obtainable say so AND WHY…"

- Pt condition
- Acuity
- Language
- Age
- No Family / Records

HPI – the Clairvoyant Coder

"…but *still document what you can* …"

- Other sources
  - Records, family, rescue, nursing notes etc

HPI – the Clairvoyant Coder

"…but *still document what you can* …"

- Other sources
  - Records, family, rescue, nursing notes etc

PM/F/S – standard teaching

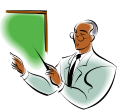
- "You need to document…."
  - Past medical history
  - Medications
  - Past surgical history
  - OB-Gyn history

PM/F/S – standard teaching

- "You need to document…."
  - Mother's medical Hx
  - Father's medical Hx
  - Grandparents Hx

PM/F/S – standard teaching

- "You need to document…."
  - Do they drink
  - Do they smoke
  - Do they do drugs
  - How much



PM/F/S – standard teaching

- "You need to document…."
  - Do they live in a NH
  - Do they live alone

PM/F/S – standard teaching

PM/F/S

- Usually going the past medical conditions
  - AND NOTHING ELSE

PM/F/S– the Clairvoyant Coder

"Document the medical & surgical history important for the patient …"

- Do they smoke – YES or NO
- Who do they live with?
- If the pts has no history you MUST documents no PMHX

ROS – standard teaching

- "You need to include at least 1 thing in 10 systems to bill a level 5…."
  - Integument
  - Cardiovascular
  - Chest
  - ENT
  - Eyes
  - Neck

- Respiratory
- Gastrointestinal
- Lymphatic
- Neurological
- Musculoskeletal
- Endocrine
- Hematologic
- Genitourinary
- Psychiatric
- Constitutional

ROS – standard teaching

ROS

- Usually going to get 6ish
  - Vary by specialty

ROS – the Clairvoyant Coder

"Do the pertinent positives & negatives…"

- Review the major organ systems
- **All systems reviewed and otherwise negative**

ROS – the Clairvoyant Coder

"If HPI is unobtainable then ROS is unobtainable…"

- Charting must be set up to support this -

PE – standard teaching

- "You need to include at least 1 (2) element(s) in 9 systems to bill a level 5…."

- …"or all elements from single system exam category"

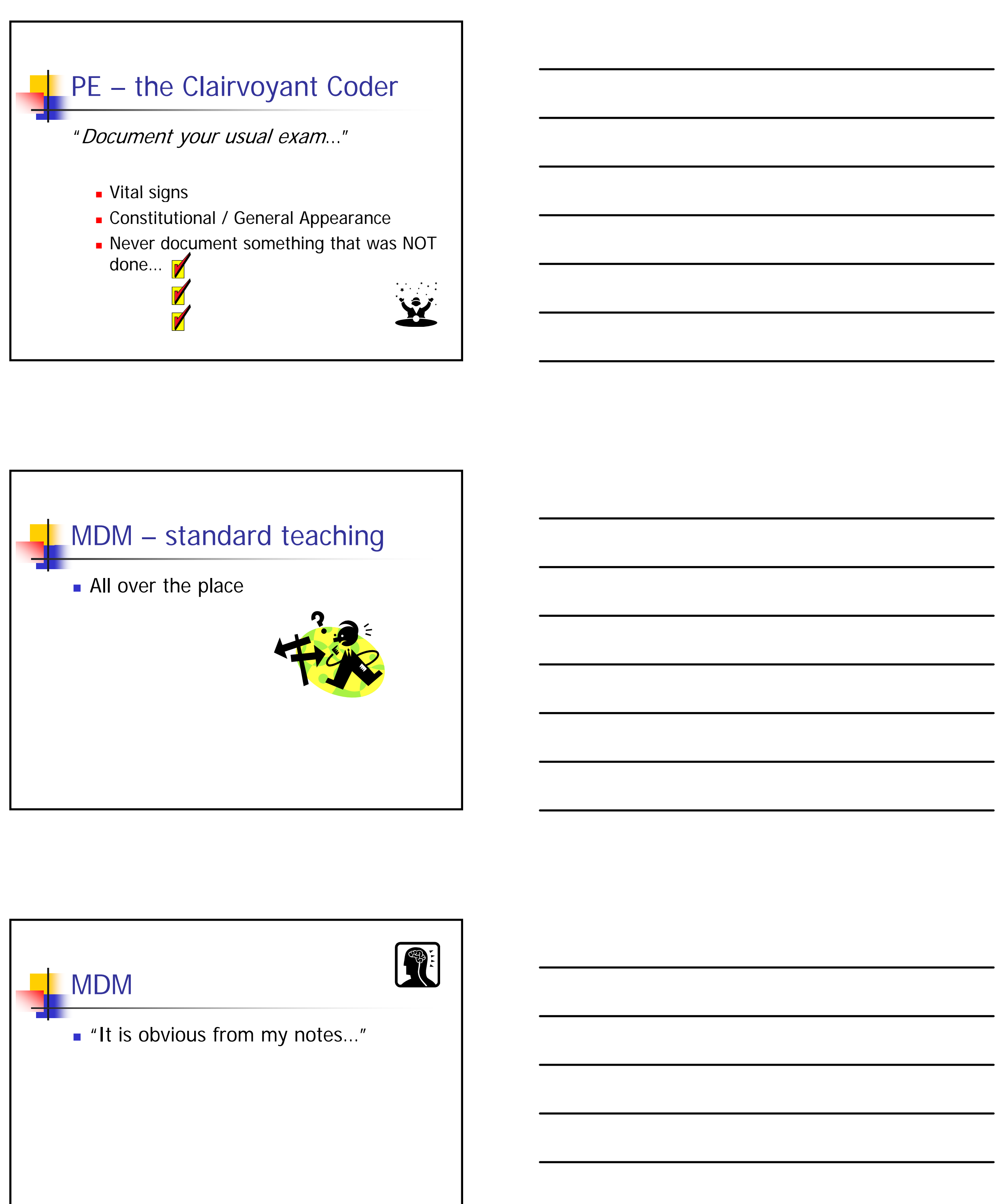
PE

- Docs are *usually* pretty good
  - It's what we consider the meat and potatoes of the patient encounter
    - even though it is not from a billing perspective

PE – the Clairvoyant Coder

"Document your usual exam…"

- Vital signs
- Constitutional / General Appearance


PE – the Clairvoyant Coder
"Document your usual exam…"
Vital signs
Constitutional / General Appearance
Never document something that was NOT done…
MDM – standard teaching
All over the place
MDM
"It is obvious from my notes…"

MDM- the Clairvoyant Coder

- Document all labs, x-rays & tests
- Document your interpretations
- Document speaking with consultants
- Perform and document re-evaluations
  - Especially after interventions

Critical Care Time

- Failure to correctly document critical care time is one of the largest areas of revenue loss for many groups

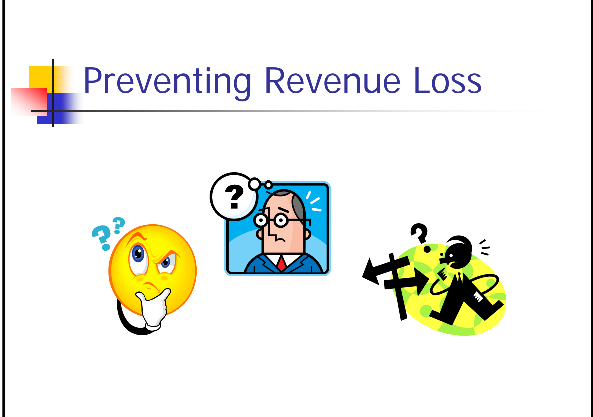
Critical Care Time

- All time spent providing care
  - Direct care
  - Lab / x-ray interpretation
  - Time spent in discussion with consultants
- Time is **cumulative** (not continuous)

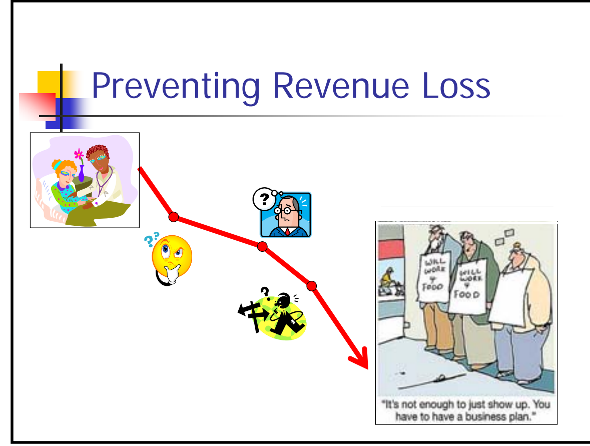
Critical Care Time

- Procedure time must be subtracted
- Diagnoses must support critical nature
- Most docs underestimate CC states

Preventing Revenue Loss



Preventing Revenue Loss



Preventing Revenue Loss

- Things are not intuitively obvious to physicians
- Understanding them will make your job easier

Procedures

- Every procedure performed by the physician (including failed procedures) should have a procedure note documented in the patient chart
  - Docs think about this in medico-legal terms
  - You think about it in terms of BILLING

Procedures – the Clairvoyant Coder

"Document the procedure the same way – every time – succeed or fail"

Procedures – the Clairvoyant Coder

- What
- Why
- How
- Who

- Time out
- EBL

Procedures – the Clairvoyant Coder

- Yes Virginia…..
  - IV starts
  - EJs
  - Foleys
  - NGs

Procedures – the Clairvoyant Coder

- Every procedure needs a supporting diagnosis
  - Central line – *hypotension, shock, dehydration*
  - Intubation - *respiratory or airway compromise*
  - LP – *HA, meningitis, fever*
  - Orthopedic reduction – *dislocation of "ABC"*
  - I & D – *"3cm right forearm abscess"*

Procedures – wounds & excisions

- Specify the location & size for EACH
  - 4 cm L forearm lac
  - 2 cm facial lac
  - 8-10 cm stage 3 decubitus ulcer
  - 17% BSA second degree burn

Procedures – wounds & excisions

- Specify the number of layers
  - And what was done to each layer
- A complex repair requires significant debridement

Procedure - oddities

- Equipment replacement must have the reason patient requires the device:
  - G-tube - *CVA, malnutrition, FTT*
  - Foley – *Urinary Retention*
  - IV – *Dehydration, infection*
  - Trach – *Tracheal stenosis*

Injury & trauma

- Specify the location for EACH process
  - R arm contusion, forehead abrasion
  - 5th phalynx fracture
  - R knee sprain
  - Low back pain
- Multiple contusions is NOT a DX

Diagnoses

- Document all diagnoses
- Use the chief complaint
- Include abnormal vital signs
  - Hypoxia, tachycardia, hypertension
- Include abnormal labs
  - ↑Glucose, ↑Na, ↓K

Diagnoses

- Document physical findings
  - Dehydration
  - Jaundice
  - Dizziness
  - Weakness
  - Fever

Diagnoses

- Add the chronic medical conditions
  - HTN
  - DM
  - CRF
  - CAD
  - EtOH abuse

Diagnoses - psychiatric

- Include all DSM dxs & medical dxs
  - MDE, Suicidal Risk, EtOH ingestion
  - Acute psychosis, SI, schizophrenia
  - SPECIFIC drug ingestion / over dose
  - Chronic medical complaints

Diagnosis - oddities

- Acute abdominal pain is NOT a diagnosis
  - Must have a location
    - RUQ
    - Epigastric
    - Lower
    - Diffuse
    - NOS

Diagnosis - oddities

- Strain must have an overuse syndrome documented in the chart
- UTI & Sepsis – not urosepsis - is a better diagnosis

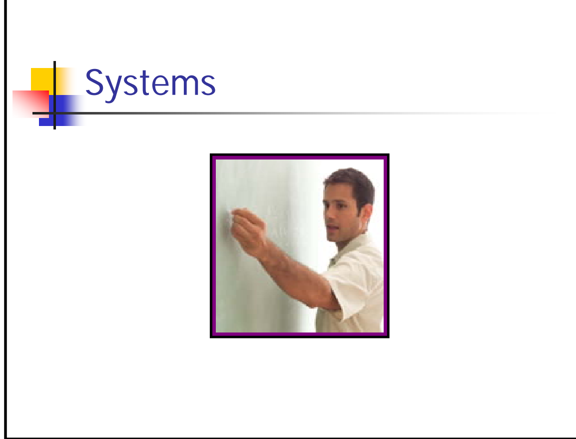
Diagnosis - gold stars

- Acute
- Sudden onset
- Severe
- Intractable
- Exacerbation
- Acute febrile illness

Diagnosis NO NOs

- Normal / Mild
- Resolved
- Medical screening*
- Medical clearance
- Med refill
- Well baby*
- Parental anxiety
- Multiple contusions
- Possible / Rule out
- Suspected
- MVA or MVC
- SI

Very few chart should have only ONE diagnosis



Systems

- Does the charting system support the physician work?
  - Is it easy to use?
  - Does it have prompts?
  - Is it logically formatted?

Systems

- Does it accomplish what it should?
  - Patient care
  - Communication
  - Billing / Coding
  - Medical - legal

EMR

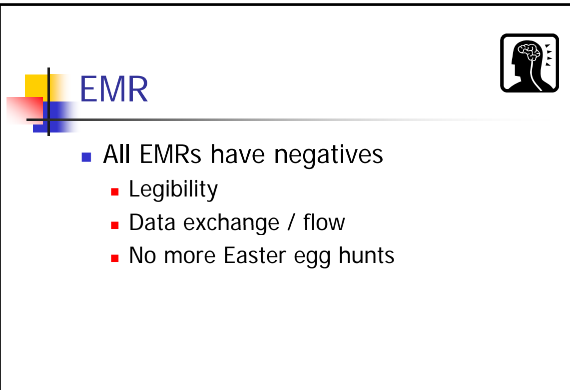
- You can tell "who" created the EMR
- Many EMRs handle linear patient encounters well
- Most EMRs do NOT handle non-linear patient encounters well

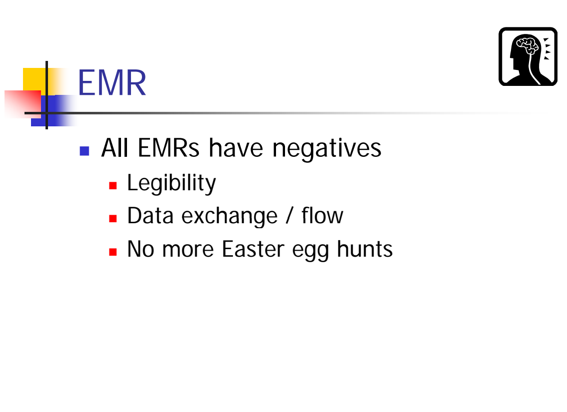
EMR

- All EMRs increase the provider work
  - Time
  - Actual work (CPOE)
  - Multiple screens

EMR

- All EMRs have positives
  - Legibility
  - Data exchange / flow
  - No more Easter egg hunts


EMR
All EMRs have negatives
Legibility
Data exchange / flow
No more Easter egg hunts


EMR
All EMRs have negatives
Legibility
Data exchange / flow
No more Easter egg hunts

EMR

EMR – the Clairvoyant Coder

- Customization
- Communication
- Persistence
- Flexibility

Cloning – standard teaching

- *Well….*

Cloning – standard teaching

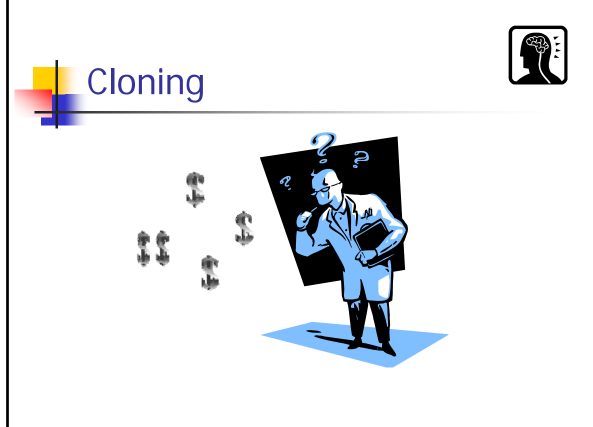
Documentation is considered cloned when each entry in the medical record for a patient is worded exactly alike or similar to the previous entries. Cloning also occurs when medical documentation is exactly the same from patient to patient. It would not be expected that every patient had the exact same problem, symptoms, and required the exact same treatment. Cloned documentation does not meet medical necessity requirements for coverage of services rendered due to the lack of specific, individual information. All documentation in the medical record must be specific to the patient and her/his situation at the time of the encounter. Cloning of documentation is considered a misrepresentation of the medical necessity requirement for coverage of services. Identification of this type of documentation will lead to denial of services for lack of medical necessity and recoupment of all overpayments made.

Cloning – standard teaching

2011 OIG Work Plan:

Medicare contractors have noted an increased frequency of medical records with identical documentation across services. We will also review multiple E&M services for the same providers and beneficiaries to identify electronic health records (EHR) documentation practices associated with potentially improper payments.

Cloning



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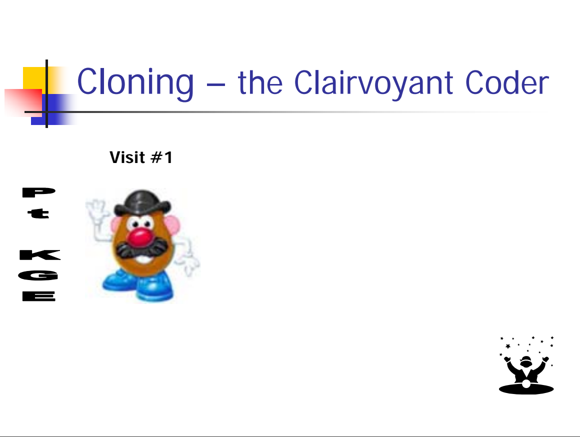

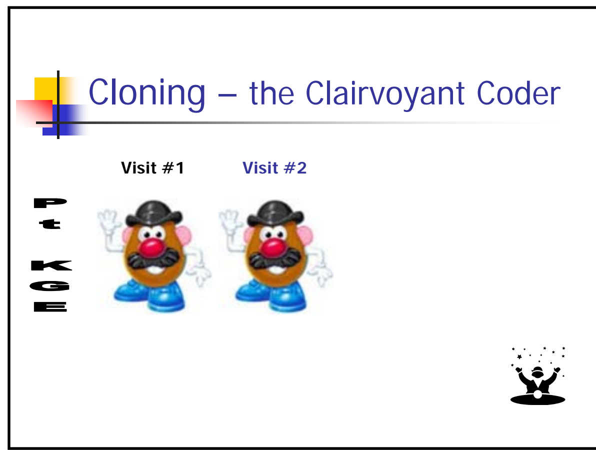
Cloning – the Clairvoyant Coder
Visit #1
Visit #2

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Visit #1
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Visit #3

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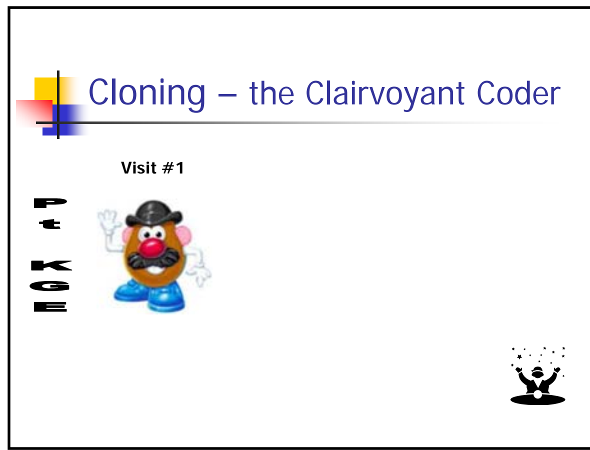
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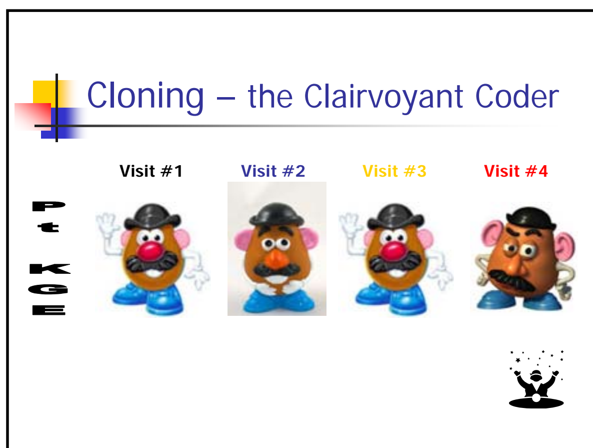
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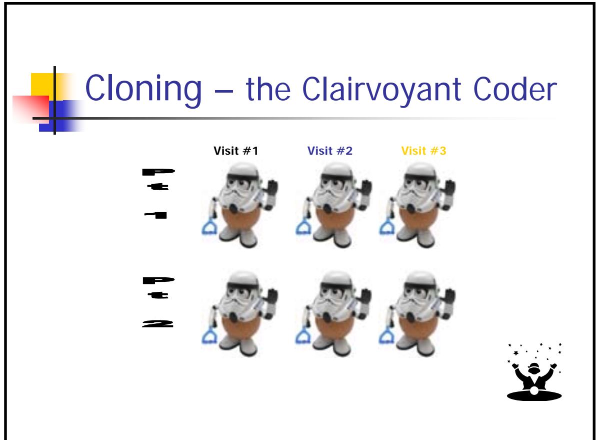
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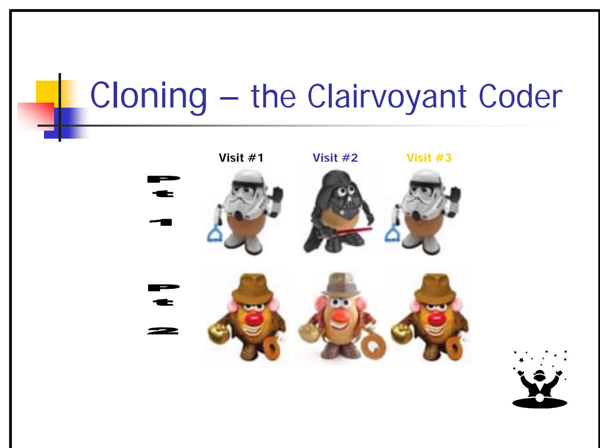
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Visit #1
Visit #2
Visit #3

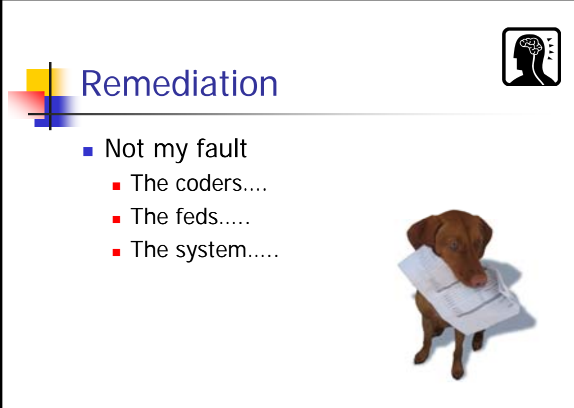
ICD-10

ICD-10 – the Clairvoyant Coder

- It is all about physician education

Remediation – standard teaching

- "This letter is to inform you only 6 of 10 chart met billing compliance. Down coding is a significant source of lost revenue. "Please correct."

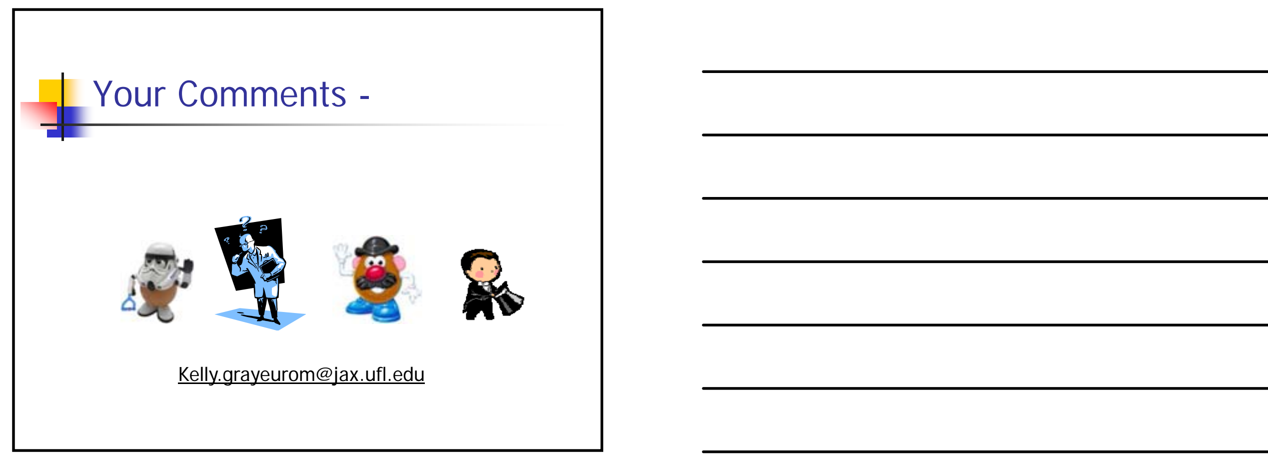


Remediation – the clairvoyant coder

- Show me the money

No Outcome No Income

- Coders aren't magic
- Charts can't be billed without signature
- If the coder can't read it (or hear it), then it doesn't matter how well the chart is documented
- If it is missing, the charges go DOWN


Your Comments -
Kelly.grayeurom@jax.ufl.edu