E&M Changes:
The Impact on Pediatrics

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Agenda for this Session	• AMA changes vs. CMS Changes • Documentation relaxation proposal • Teaching physician changes

Before we begin…

I.   INTRODUCTION

WHAT IS DOCUMENTATION AND WHY IS IT IMPORTANT?

Medical record documentation is required to record pertinent facts, findings, and observations about an individual's health history including past and present illnesses, examinations, tests, treatments, and outcomes. The medical record chronologically documents the care of the patient and is an important element contributing to high quality care. The medical record facilitates:

•   the ability of the physician and other health care professionals to evaluate and plan the patient's immediate treatment, and to monitor his/her health care over time.

•   communication and continuity of care among physicians and other health care professionals involved in the patient's care;

•   accurate and timely claims review and payment;

•   appropriate utilization review and quality of care evaluations; and

•   collection of data that may be useful for research and education.

An appropriately documented medical record can reduce many of the "hassles" associated with claims processing and may serve as a legal document to verify the care provided, if necessary.

1.   The medical record should be complete and legible.

2.   The documentation of each patient encounter should include:

•   reason for the encounter and relevant history, physical examination findings and prior diagnostic test results;

•   assessment, clinical impression or diagnosis;

•   plan for care; and

•   date and legible identity of the observer.

3.   If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.

4.   Past and present diagnoses should be accessible to the treating and/or consulting physician.

5.   Appropriate health risk factors should be identified.

6.   The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented.

7.   The CPT and ICD-9-CM codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.

CMS
vs.
Commercial
Carriers
vs.
State Medicaid
Plans

"I suppose I'll be the one
to mention the elephant in the room."

Interval Level Documentation

- *For established patient office/outpatient visits, when relevant information is already contained in the medical record, <u>practitioners may choose to focus their documentation on what has changed since the last visit, or on pertinent items that have not changed, and need not re-record</u> the defined list of required elements if there is evidence that the practitioner reviewed the previous information and updated it as needed.*

- *Practitioners should still review prior data, update as necessary, and indicate in the medical record that they have done so;*

Pitfalls with Look-Back Documentation Style

- The #1 concern: Refer back may fail to demonstrate medical necessity
  - For today's encounter
  - For test/procedures ordered
  - Documenting effectively medical indications for a surgical procedure
- Another concern: How do you score it? Do we ONLY count the updated elements for today's encounter?
- Exposed risk for additional encounter review
  - The documentation that was referred to is not part of today's encounter
  - This could prove problematic with submitting records for a carrier (or even 3rd party) audit

Visit Information
Previous visit: none.
</LCI>
History of Present Illness: Unchanged from previous visit documented above.

Histories

Past Medical History: Unchanged from previous visit documented above.

Family History:
Unchanged from previous visit documented above

Social History:
Unchanged from previous visit documented above

Health Status

Allergies: Allergic Reactions (Selected)
NKA

Review of Systems: Unchanged from previous visit documented above

Physical Examination: Unchanged from previous visit documented above

VS/Measurements: Vital Signs (most recent within last year)
Temperature 36.8 (01/08/19 14:51)
Heart Rate 78 (01/08/19 14:51)
Resp Rate 20 (01/08/19 14:51)

Assessment:

Airway Exam: Dentition poor dentition but not loose teeth.

ASA Classification: ASA II.

Airway Assessment: Mallampati Classification: Class II.

Sedation Plan: Moderate Sedation.

Immediate Pre-Procedure Airway Assessment: Completed.

Plan

Plan:

Patient presents for: Urgent (TEE).

TEE: Transesophageal echocardiography. A diagnostic test to make images of the heart chambers and surrounding structures.

TEE may be used, for example, in the treatment of children having heart surgery. TEE has unusually accurate imaging capabilities that permit the identification of previously unidentified anatomic features and postoperative surgical results that may necessitate a change in surgical plan or surgical revision before the child leaves the operating suite.

CMS Published FAQ

- **What parts of the history can be documented by ancillary staff or the beneficiary starting in CY 2019?**
  - The CY 2019 PFS final rule expanded current policy for office/outpatient E/M visits starting January 1, 2019 to provide that any part of the chief complaint (CC) or history that is recorded in the medical record by ancillary staff or the beneficiary does not need to be re-documented by the billing practitioner.
  - Instead, when the information is already documented, the billing practitioner can review the information, update or supplement it as necessary, and indicate in the medical record that she or she has done so.
  - This is an optional approach for the billing practitioner, and applies to the chief complaint (CC) and any other part of the history (History of Present Illness (HPI), Past Family Social History (PFSH), or Review of Systems (ROS)) for new and established office/outpatient E/M visits.
  - To clarify terminology, we are using the term "history" broadly in the same way that the 1995 and 1997 E/M documentation guidelines use this term in describing the CC, ROS and PFSH as "components of history that can be listed separately or included in the description of HPI."
  - This policy does not address (and we believe never has addressed) who can independently take/perform histories or what part(s) of history they can take, but rather addresses who can document information included in a history and what supplemental documentation should be provided by the billing practitioner if someone else has already recorded the information in the medical record.

For the purposes of payment, E/M services billed by teaching physicians require that the medical records must demonstrate:

1) That the **teaching physician performed** the service <u>or</u> was **physically present** during the key or critical portions of the service when performed by the resident; and

2) The **participation** of the teaching physician in the management of the patient.

In addition, the patient **medical record must document the extent of the teaching** physician's participation in the review and direction of the services furnished to each beneficiary.

The extent of the teaching physician's participation may be demonstrated by the notes in the medical records **made by physicians, residents, or nurses.**

Teaching Physician Changes

CMS 2021
Changes
vs.
AMA 2021
Changes

AMA Guidelines Change

- Restructuring the Guidelines into 3 sections:
  - Guidelines Common to All E/M Services
  - Guidelines for Hospital Observation, Hospital Inpatient, Consultations, Emergency Department, Nursing Facility, Domiciliary, Rest Home or Custodial Care and Home E/M Services
  - Guidelines for Office or Other Outpatient E/M Services
- All in an effort to distinguish the new reporting guidelines for the Office or Other Outpatient Services codes 99202-99215;

Adding New Guidelines

- New guidelines that are applicable only to Office or Other Outpatient codes (99202-99215)
- A Summary of Guideline Differences **table** of the differences between the different sets of guidelines
- And, revising the existing E/M guidelines to ensure there is no conflicting information between the different sets of guidelines

Miscellaneous AMA Adds…

- Adding definitions of terms associated with the elements of MDM applicable to codes 99202-99215
- Adding a MDM table that is applicable to codes 99202-99215
- Defining total time associated with codes 99202- 99215
- Adding guidelines for reporting time when more than one individual performs distinct parts of an E/M service

Deletion of 99201

CMS & AMA AGREE

E A S Y
BREEZY

Reimbursement
Model Change

- Collapsed payment model
- Blended payment amount
- Flat fee amount

MEDICARE HEALTH INSURANCE

1-800-MEDICARE (1-800-633-4227)

NAME OF BENEFICIARY
JOHN DOE

MEDICARE CLAIM NUMBER   SEX
000-00-0000-A   MALE

IS ENTITLED TO   EFFECTIVE DATE
HOSPITAL (PART A)   01-01-2007
MEDICAL (PART B)   01-01-2007

SIGN
HERE

SAMPLE
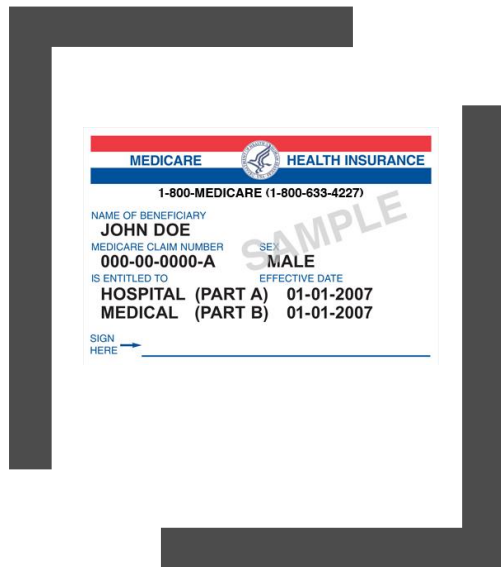
Reimbursement Model Change

- This proposed change only impacts outpatient/office based services
- This does **NOT** impact level 99201, 99211, 99215, or 99205
- This change only impacts:
  - 99202-99204
  - 99212-99214

So What is the Flat Rate? (Approximately)

New Patient Flat Rate:	•$129.24
Established Patient Flat Rate:	•$88.92

AMA CPT Changes

Reimbursement is NOT mentioned in the AMA changes

Documentation Relaxation

- BOTH AGREE!
- Although CMS has "finalized" and AMA requested comments until 3-25-2019
- The Final Rule will allow the provider to choose their documentation style:
  - Medical Decision Making (MDM) ONLY, or
  - Time ONLY, or
  - Continue to use the current E&M framework
- Regardless, the highest level of documentation required is a level 2

History & Exam

- This would create documentation in which the requirement for history and/or examination would be what is being deemed as "medically appropriate"

- Will this create problems?

- If so- what problems do you see?

Don't be confused by 2021 changes!
They are NOT eliminating the need for history and exam….
They ARE eliminating our need to score it!

Documentation Relaxation: MDM Only

CMS, in the final rule was still requesting comments regarding a focus of documentation support ONLY on medical decision making

Which ones?

1995 & 1997 Documentation Guidelines for MDM	Marshfield Clinic Guidelines for MDM

Is there a difference?

Compare The Two Yourself

MDM According to the AMA
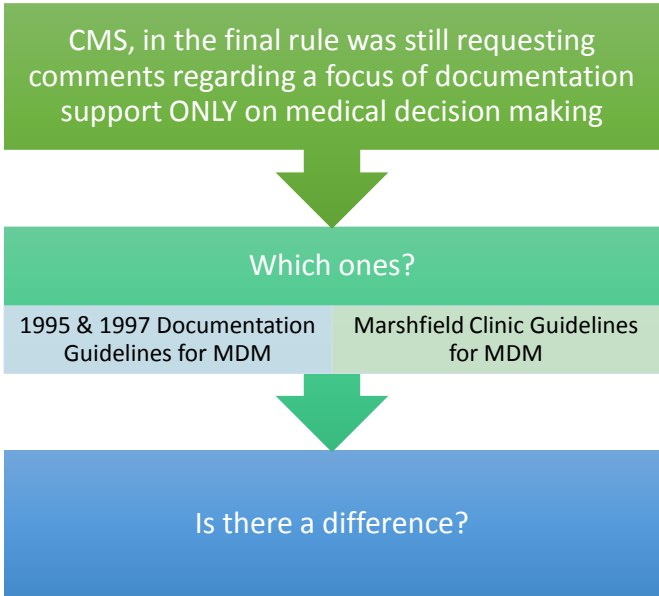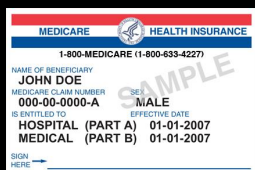
- Revision of the MDM Elements
- Diagnosis Scoring
  - "Number of Diagnoses or Management Options"
  - "Number and Complexity of Problems Addressed"
- Amount of Data/Complexity
  - "Amount and/or Complexity of Data to be Reviewed"
  - "Amount and/or Complexity of Data to be Reviewed and Analyzed"
- Table of Risk
  - "Risk of Complications and/or Morbidity or Mortality"
  - "Risk of Complications and/or Morbidity or Mortality of Patient Management"

Hmmmm, wonder where the AMA got their info?

Documentation Relaxation: Time Only

- **No longer** would have a requirement that counseling and coordination of care dominate the encounter
- A provider could choose to bill any and all encounters based on time
- Time Requirements:
  - New Patient:
    - 38 minutes (20 minute threshold)
  - Established Patient:
    - 31 minutes (16 minute threshold)
- CMS proposes that as per CPT Guidance allows provided the threshold is met- the encounter is still supported.

AMA on Time ONLY

- Change the definition of the time element associated with codes 99202-99215 from typical face-to-face time to total time spent on the day of the encounter, and changing the amount of time associated with each code

Documentation Relaxation:
Existing Framework- Same for both

Maintain the way providers are currently documenting

Documentation requirements would not exceed that of a level 2 encounter

New patient:

1 HPI 1 ROS 0 PFSH
2 Organ system exam
SF MDM

Established patient:

1 HPI 0 ROS 0 PFSH
1 Organ system exam
SF MDM
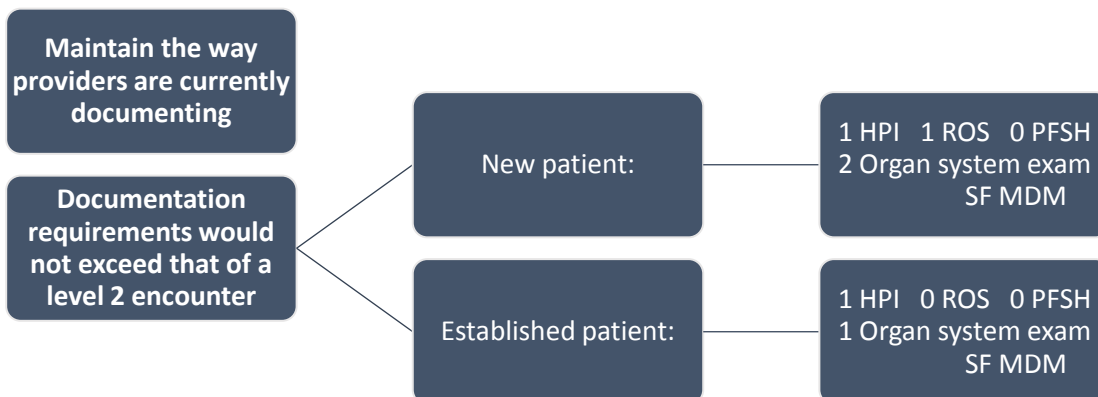
99205/99215

- Since CMS has maintained the integrity of the level 5 encounters they are making the documentation requirements different from the level 2-4 encounters.

- Documentation Requirements:
  - Current Framework
  - MDM must be met as it exist for the level 5
  - Time based documentation- however they maintained the current time framework for the level 5
    - 60 minutes new / 40 minutes established
    - Counseling and Coordination of Care REQUIRED

  Page 568 of the Final Rule Document

MEDICARE HEALTH INSURANCE

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NAME OF BENEFICIARY
JOHN DOE
MEDICARE CLAIM NUMBER   SEX
000-00-0000-A   MALE
IS ENTITLED TO   EFFECTIVE DATE
HOSPITAL (PART A)   01-01-2007
MEDICAL   (PART B)   01-01-2007

SIGN
HERE

SAMPLE

99205/99215

- Definitely a contradiction as AMA CPT has decided that all relaxation rules WILL apply to this code set
- Therefore, for carriers NOT following CMS guidance:
  - History and exam of level 5 encounters will NOT be scored
  - Time will be updated
  - MDM could be the controlling factor

New Medicare Codes

Effective 2021

2021 New Code:

GPRO1- Extended Visit

GPC1X- Primary Care Services

GCG0X Specialty Services

G codes are unique to CMS and rarely do commercial carriers cover these services. Therefore, based on Pediatrics this is good information, but probably not applicable.

What is your Game Plan?

PLAN 2019 remember

1. Create an organizational policy regarding referring back
2. Create an organizational policy regarding ancillary staff & HPI
3. Ensure that all coders and auditors are educated on these
4. Educate your providers on the CMS rules and concerns
5. Check with your MAC often for additional guidance
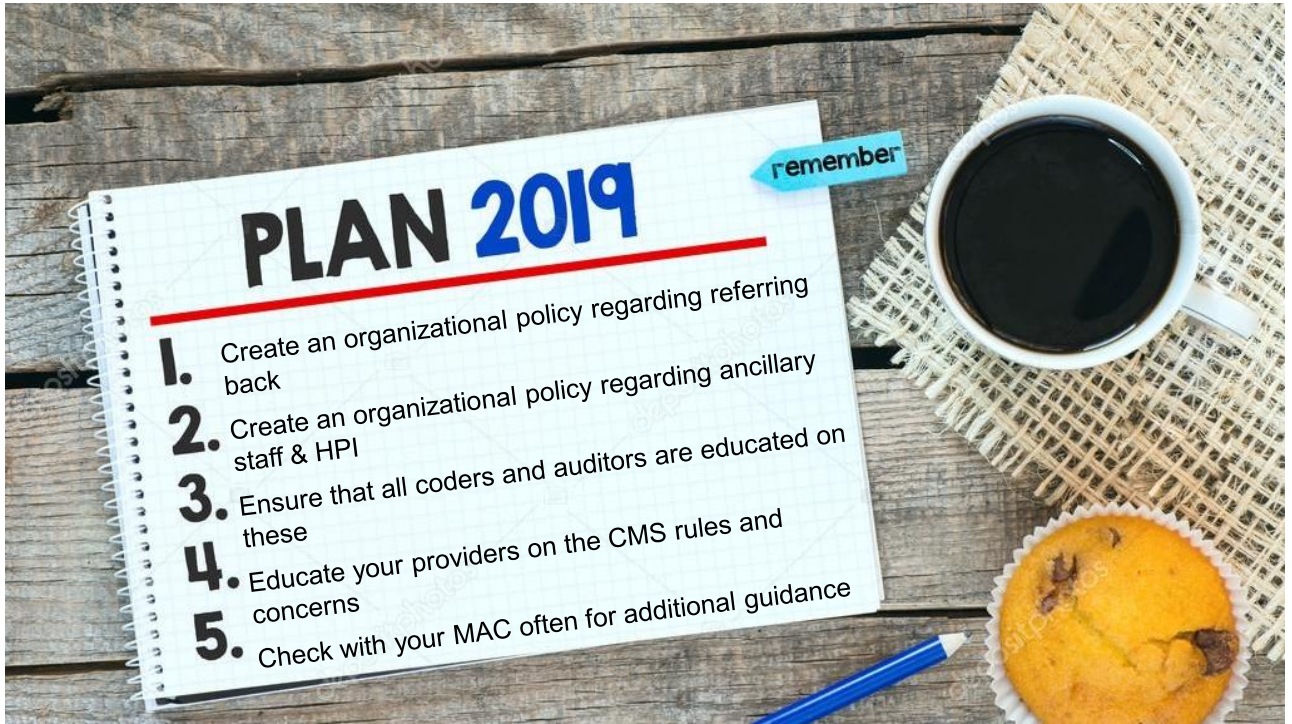
Electronic Documentation Concerns

Areas that create compliance risks

Addendums & Late Entry

Addendums supply information that was not available at the time of the original documentation.

The documentation of the addendum includes the additional information as well as the reason for the addition.

Addendums are to be done in a timely manner and must include the current date and signature of the person making the addendum.

Late Entry

- Documentation of an encounter is expected to be created "immediate"- within 24-48 hours
- Entries that exceed this threshold would be considered as late entries into the medical record
- This applies to documentation and signatures on documentation

Addendum & Late Entry Policy

CMS currently does NOT indicate a time frame for an addendum, nor for late entries

Your organization, no matter how large or small, should delineate such expectations through a policy

Your policy should include:

- Implementation date of the policy
- Definition of an addendum, to include the difference between late entries
- How to create a compliant addendum and late entry
- Appropriate time frames of each

Timeframe considerations:

- Has the claim dropped?
- Have we been reimbursed?
- Why is the addendum being created?
- Frequency or pattern of the provider regarding addendum use

Corrections

Corrections in a medical record can never obliterate or delete the original documentation.

In many EMR systems strike through is not an option, so the correction is made with an addendum to the note, never by deleting the error and correcting it.

Corrections are to be signed by the person making the correction and dated with the current date.

Corrections are need to modify information in the medical record that is wrong on represents a noted contradiction.

Corrections

Corrections can be made with a single line strike through as long as the original documentation is still identifiable- again think paper charts as this does not work in an electronic medical record.

Each needed correction should be signed or initialed and date

The author should indicate the reason for correction above or in the margin

Document the correct information on the next line or space with the current date and time, making reference back to the original entry.

Correction of electronic records should follow the same principles of tracking both the original entry and the correction with the current date, time, reason for the change and initials of person making the correction.

When a hard copy is generated from an electronic record, both records must show the correction. Any corrected record submitted must make clear the specific change made, the date of the change, and the identity of the person making that entry.)

Corrections Policy

CMS currently does NOT indicate time frame for when a correction should be made

Your organization, no matter how large or small, should delineate such expectations through a policy

Your policy should include:

- Implementation date of the policy
- Definition of a correction to ensure there is no confusion as to what the intent of a correction is according to this policy
- How to correct a medical record according to compliance requirements
- Time frame of when addendums should be *suggested*. While corrections should be timely and relevant, an aberrant error in medical documentation should be updated regardless of how long after the creation of the encounter.

Other considerations:

- Will the correction impact the services that were billed?
- Will the correction impact the reimbursement of the billed services?
- Have the medical records been used for any purpose prior to the correction?
- If so, should updated records be redistributed?

Cloning

Medicare defines cloning as multiple entries in a patient chart that are identical or similar to other entries in the same chart.

Cloning is a misrepresentation of the medical necessity required for services rendered.

Cloning is considered inappropriate if it is not accompanied by a statement from the provider rendering the service that the information is carried forward for informational purposes only and not utilized in supporting the encounter level of service.

Many carriers have determined that encounters with cloning should be down-coded since the level of "Medical Necessity" nor the work of the elements (HX, EX, and MDM) cannot be determined for the billing provider.

Cloning

- From a carrier perspective….
  - You have a patient that has been coming to the practice for the past 10 years for long term management of OA of right knee and left hip
  - Blue Mutual Insurance has requested to review the last 5 encounters
  - We lay the encounters down side by side, and the documentation is identical
- The carriers response…
  - Prove to us what work was done on visit 2 vs 3, 4, and 5
  - If there was no relevant need to change the documentation, then maybe the medical necessity to warrant to the encounter did not exist

- WE FAIL TO REMEMBER…. DOCUMENTATION MATTERS!

Cloning Policy

CMS addresses cloning within the context of copy & paste. To ensure a full understanding of policy, we recommend you address the individually through policy

Your organization, no matter how large or small, should delineate such expectations through a policy

Your policy should include:

- Implementation date of the policy
- Definition of cloning to include a few examples to ensure understanding. Within this definition you separate cloning from copy & paste
- Identify how cloned documentation will be handled internally
  - Impact on daily coding
  - Compliance audits and precision ratings
  - Escalation policy should the matter continue

Other considerations:

- You might consider contacting your liability carrier regarding E&O coverage criteria for known cloning incidences
- Consider getting legal advise from a HEALTH LAW Attorney

Templates & Macros (..phrases)

Using predefined text and text options to document the patient visit within a note

Problems can occur if the structure of the note is not a good clinical fit and does not accurately reflect the patient's condition and services

These features may encourage overdocumentation to meet reimbursement requirements even when services are not medically necessary or never delivered

Templates & Macros (..phrases)

- Don't be mistaken, CMS DOES allow the use of templates, macros, and ..phrases
- Consider standing orders- why does CMS have a negative approach to standing orders?
- When using the efficiencies within the documentation process, ensure the following:
  - NO CONTRADICTIONS ARE CREATED!
  - Information entered as work completed as part of the encounter represents work that WAS done on that date of service
  - Use to your benefit and not your detriment

Templates & Macros (..phrases) Policy

CMS indicates that these forms of documentation can be utilized, but they indicate significant concerns in their use

Your organization, no matter how large or small, should delineate such expectations through a policy

Your policy should include:

- Implementation date of the policy
- Definition of each of these efficiencies
- Identify how errors, contradictions, and inappropriate use will be handled internally:
  - Impact on daily coding
  - Compliance audits and precision ratings
  - Escalation policy should the matter continue

Other considerations:

- Train your staff- ALL of your staff on the use of each
- Be sure to identify the risks associated with creating a false record, legal considerations of a contradictory record, and the risk of abuse (not fraud)

Copy Paste

- Selecting data from one location and reproducing it in another, also called "cookie cutter, copy forward, and cut and paste."
- Health care professionals have stated that copying and pasting notes can be appropriate and eliminate the need to create every part of a note and re-interview patients about their medical histories.
- However, HHS-OIG identifies "illegitimate use of cut and paste record cloning" as a problem
- HHS-OIG's 2016 Compendium of Unimplemented Recommendations found that only about one-fourth of hospitals had policies governing the use of the copy-paste function in EHR software
- Defaulting or copying and pasting clinical information from different health care records of the same patient facilitates billing at a higher level of service than was actually provided
- For example, in a summary of one company's recent self-disclosure settlement, HHS-OIG said the EHR contained cloned patient progress notes and that they up-coded several services
- BUT, if you are using **MEDICAL NECESSITY** as the overarching criterion- up-coding is not as common

Copy Paste- FABRICATION CONCERNS?

- EHRs can also make it easier to fabricate documentation and hide the fraud
- Users can copy, paste, and edit large amounts of text with much less effort than fabricating it by hand
- The 2012 joint letter mentioned previously conveyed concern that some providers might be using EHR systems to clone medical records
- For example, in 2013 a pediatric dentist in Texas and a supervisor of a mental health services provider in Florida were found guilty of fabricating records to support bills for nonexistent services

Copy & Paste

- Morale of the story:
  - C&P is allowed per CMS
  - CMS does NOT indicate what areas of documentation may or may not be C&P'd
- Therefore, when you find providers taking advantage of C&P, unless you have a policy identifying what is allowed and what is not it is hard to stand by the audit findings that deny deficient records

Copy & Paste Policy

CMS indicates that C&P may be utilized, but they indicate significant concerns in overuse!

Your organization, no matter how large or small, should delineate such expectations through a policy

Your policy should include:

- Implementation date of the policy
- Definition of C&P
- Best recommendation is to take each key component and element and identify if your organization would allow C&P
  - HPI- C&P should NOT be allowed
  - ROS & PFSH- C&P should be allowed
  - Exam- ???
  - MDM- C&P Should NOT be allowed

Other considerations:

- How will records that include C&P be coded/audited?
- Will you have an escalation policy for those providers not meeting expectations?
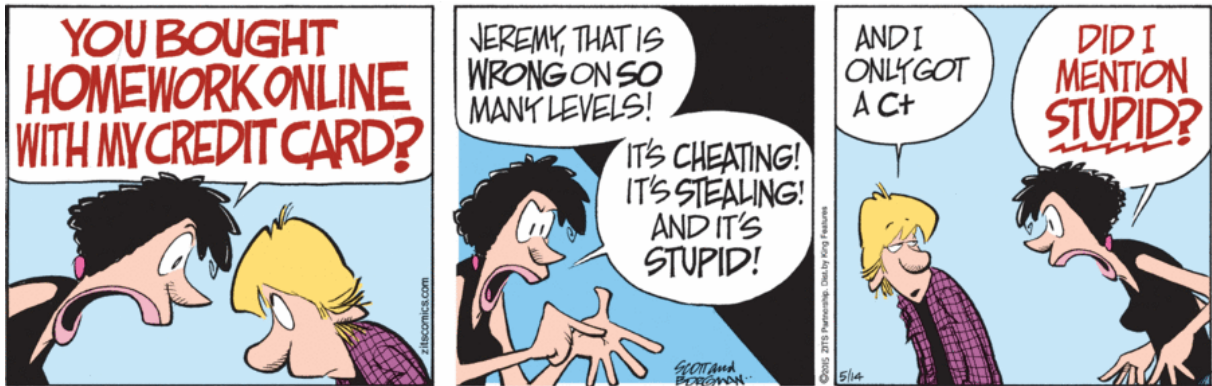
Clinical Plagiarism

Clinical Plagiarism

Clinical plagiarism occurs when a provider copies and pastes information from another provider and calls it his or her own

Defaulting or copying and pasting clinical information from different health care records of the same patient facilitates billing at a higher level of service than was actually provided.

Clinical Plagiarism

How did we get here?

- Copy Paste….
- Most providers do not understand that this is "a thing" and merely part of copy and paste

This is NOT a valid form of documentation
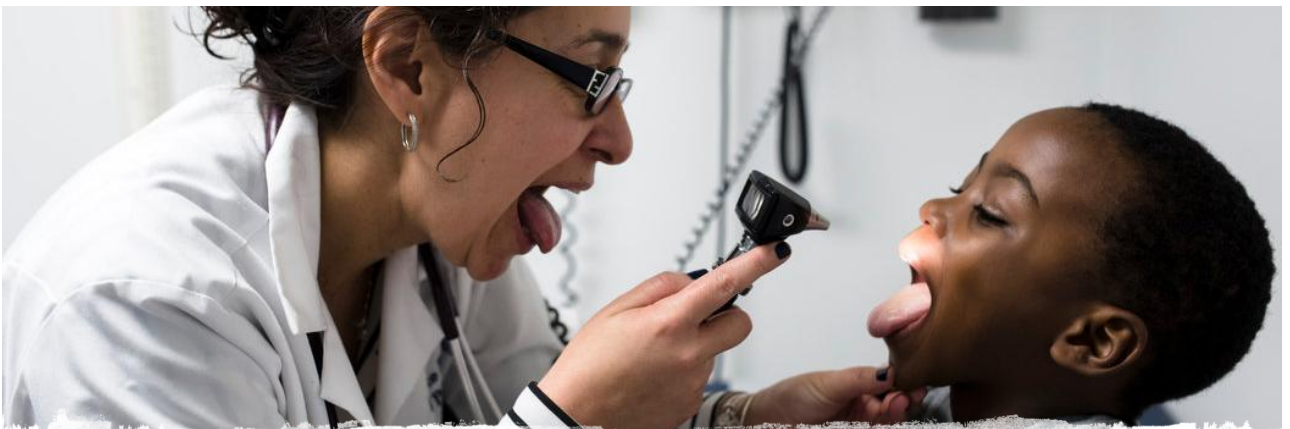
Clinical Plagiarism

- Copy/Paste or Copy/Forward of medical student notes is not allowed, except as allowable by regulations
- Copy/Paste or Copy/Forward of a split-shared encounter is a bit controversial- you will certainly need a policy on this

Clinical Plagiarism Policy

CMS indicates records MAY NOT be plagiarized!

Your organization, no matter how large or small, should delineate such expectations through a policy

Your policy should include:

- Implementation date of the policy
- Definition of Clinical Plagiarism
- Directive as to how this will impact:
  - Coding of services plagiarized
  - Retrospective audits of plagiarized documentation
  - Precision scores
  - Audit escalation policies
  - Impacts on billed or reimbursed services

Other considerations:

- You might consider contacting your liability carrier regarding E&O coverage criteria for known cloning incidences
- Consider getting legal advise from a HEALTH LAW Attorney

In a changing world …

EMBRACE CHANGE – AND PROSPER!

2021 E&M Changes

You still have….

532 days

12,768 hours

766,080 minutes

To create a plan, and more importantly await more guidance

Questions?

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