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Medical Billing Compliance
Hotline 1-800-351-2831

Judy Harris, Director of Compliance
David J. Leffell, M.D., Deputy Dean for Clinical Affairs
Sally Chesney, Associate Director PFS

Medical Record Documentation - Do's and Don'ts'

On 4/20/06, Medicare issued some key points about documentation and billing. These included:

• The medical record documentation must be generated at the time of service or shortly thereafter. Delayed entries within a reasonable time frame (24-48 hours) are acceptable for purposes of clarification, error correction, the addition of information not initially available, and if certain unusual circumstances prevented the generation of the note at the time of service.

• The medical record cannot be altered. Errors must be legibly corrected so that the reviewer can draw an inference as to their origin. These corrections or additions must be dated, preferably timed, and legibly signed or initialed.

• Every note must stand alone, i.e., the performed services must be documented at the outset. Delayed written explanations will be considered. They serve for clarification only and cannot be used to add and authenticate services billed and not documented at the time of service or to retrospectively substantiate medical necessity. For that, the medical record must stand on its own with the original entry corroborating that the service was rendered and was medically necessary.

• If the provider elects to report the level of service based on counseling and/or coordination of care, the total length of time of the encounter must be documented in the medical record. Generally, the time must be documented when billing for all time-based codes, such as critical care, prolonged services, hospital discharge services, and others.

• All entries must be legible to another reader to a degree that a meaningful review may be conducted. All notes should be dated, preferably timed, and signed by the author. In the office setting, initials are acceptable as long as they clearly identify the author. If the signature is not legible and does not identify the author, a printed version should be also recorded.

• Cloning of Medical Notes - Documentation is considered cloned when each entry in the medical record for a patient is worded exactly like 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.

• Volume of Documentation vs. Medical Necessity - The Social Security Act, Section 1862 (a)(1)(A) states: "No payment will be made … for items or services …not reasonable and necessary for the diagnosis or treatment of an injury or illness or to improve the functioning of a malformed body member." This medical reasonableness and necessity standard is the overarching criterion for the payment for all services billed to Medicare. Providers frequently "over document" and consequently select and bill for a higher-level E/M code than medically reasonable and necessary. Word processing software, the electronic medical record, and formatted note systems facilitate the "carry over" and repetitive "fill in" of stored information. Even if a "complete" note is generated, only the medically reasonable and necessary services for the condition of the particular patient at the time of the encounter as documented can be considered when selecting the appropriate level of an E/M service. Information that has no pertinence to the patient's situation at that specific time cannot be counted.

Consultation Chaos

The consultation article in the March 2006 Alert generated quite a few questions and concerns about the requesting physician's responsibility to document the request and reason for a consult in the patient's medical record. Often our practitioners have no control over what a requesting physician records in the patient's medical records. According to the Physician Regulatory Issues Team (PRIT) website, the following is stated:

"In December of 2005 transmittal 788 imposed the additional requirement that the consulting physician verify that a written request for a consultation has been made in the patient chart before billing for the consultation. The MGMA has asked that this requirement be reconsidered. The PRIT is discussing the issue with appropriate staff.

April 12,2006: We (PRIT) do not expect the consulting physician to verify that the ordering physician has documented the consultation request in the patient chart."

That said, it is still incumbent upon the requesting physician to document the request and need for the consult in the medical record. In the event of an external audit, consult services could be subject to down coding to a visit if the request and reason for the consult are not in the requesting physician's medical record.

Teaching Physician Reminders

For endoscopies, a resident may include a note that states the teaching physician was present for the entire procedure. At a minimum, the teaching physician must be present for the insertion, viewing and removal. The teaching physician must sign the endoscopy report.

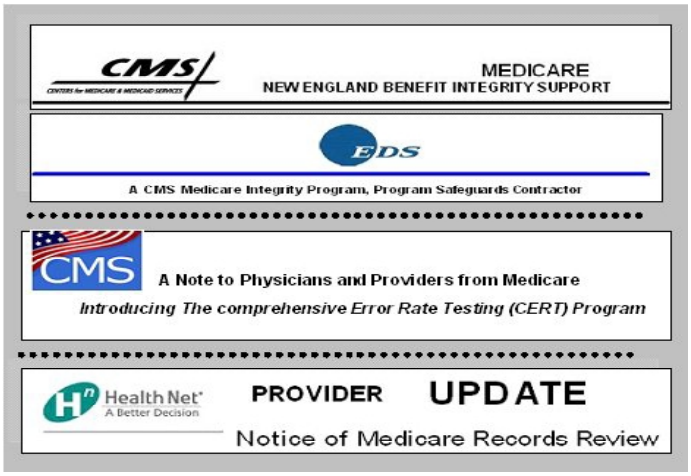
"Patient seen and examined" does not support that you, the teaching attending, saw the patient. For clarity, a teaching physician's note should state "I saw and evaluated the patient." The key points of the visit and the teaching attending's participation in the plan must be personally documented as well by the attending.

Be On The Lookout For Audit Correspondence

Our practice routinely receives letters which signify that an external audit is being conducted. According to the Yale Medical Group Compliance Manual:

"The federal government and other third party payors periodically audit the bills of health care providers. Any individual at YSM who receives notice of such an audit shall immediately advise and provide the Director of Compliance with a complete copy of the notice."

AdvanceMed, Lifecare Management Partners, The Center for Medicare and Medicaid Services (CMS), Medicaid Quality Assurance and private payors may conduct audits of our practice. Below are samples of letterhead that usually signify an audit request. Any correspondence bearing one of these letterheads should be faxed to Judy Harris, Director of Compliance, 785-7955.



COMPLIANCE PROGRAMS-PREVENTATIVE MEDICINE FOR HEALTH CARE PROVIDERS
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Yale
Medical
Group
PO Box 9805
New Haven, CT
06536-0805

Please contact Judy Harris by Email at judy.harris@yale.edu or at 785-3868 with questions