Teaching Physician
Compliance
ALERT
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Documentation Timelines

Wisconsin Physician Services (WPS), a Medicare contractor, recently published this Q&A. The Q&A is applicable nationally.

Question: I am confused concerning the timeliness of my documentation in connection with the provider signature, submitting the claim to Medicare, the 30-day rule, and the timely filing rule. Can you provide more information?

Answer: There are several provisions that may affect "timeliness" when talking about documentation. **The first is that a provider may not submit a claim to Medicare until the documentation is completed.** Until the practitioner completes the documentation for a service, including signature, the practitioner cannot submit the service to Medicare. Medicare states if the service was not documented, then it was not done.

The second is that practitioners are expected to complete the documentation of services "during or as soon as practicable after it is provided in order to maintain an accurate medical record." CMS does not provide any specific period, **but a reasonable expectation would be no more than a couple of days away from the service itself.**

In addition, CMS has a statement in the Internet Only Manual Section 3.3.2.4 discussing the requirements for practitioner signature, "Providers should not add late signatures to the medical record", (beyond the short delay that occurs during the transcription process) ... "If a provider delays in recording (and verifying if transcribed) the documentation of a service, the accuracy of the documentation could be compromised."

The third is the 30-day information regarding late entries. A provider should never add a signature to a medical record after the times discussed above. If a practitioner does not affix a signature at the time of the service (also allowing limited delay due to transcription), then the provider may complete an attestation statement. In addition, the Manual makes the statement "shall give less weight" when the documentation is created more than 30 calendar days after the service.

This 30-day rule may apply two ways. The first is when the practitioner **does not complete documentation within 30 days of the service. In these cases, Medicare will not accept the documentation and could deny the service.** The second is when the documentation shows it was completed at or shortly after the service, but the signature was not added. As stated above, do not add a late signature, but instead use the attestation statement. One misconception we have heard indicates that if the documentation of the service is completed more than 30 days after the service, the attestation statement will waive the requirement. This is incorrect. The fourth provision is the timely filing limit. This does not apply to the medical record documentation but instead indicates that a practitioner has one year from the date of service to file the claim to Medicare. If Medicare does not receive the claim within that year, Medicare does not make payment and the patient is not liable.

The Q&A may be found at: http://www.wpsmedicare.com/part_b/claims/submission/documentation-timelines.shtml

In addition to this Q&A, CMS recently published Med Learn Matters SE1237, which provides guidance for amendments, corrections, and delayed entries in medical documentation. The key points are (i) clearly and permanently identify any amendments, corrections, or addenda; (ii) clearly indicate the date and author of any amendments, corrections, or addenda; and, (iii) clearly identify all original content (do not delete).

Data Reviewed in E&M Audits

A health care group recently asked Medicare what documentation should be considered when auditing an Evaluation and Management (E&M) service. Here's how Medicare carrier WPS addressed this topic in a Q&A:
"Q 17. This question pertains to an Electronic Medical Record (EMR.) We have always been taught that the progress note "stands alone." When we are auditing physician's notes to determine if they are billing the appropriate level of service, what parts of the EMR can be used toward their levels without requiring them to reference it? We are referring specially to Growth charts, Past, Family, & Social History, Medication Listings, Allergies, etc.
A 17. If the physician were not referencing previous material in the EMR, then the information would not be used in choosing the level of E&M service."

The old adage still applies to the EHR—If it's not documented, it wasn't done.

Sign Your Orders!

In MLM Matters SE1237, Medicare states that signature attestations are not acceptable for orders. If the signature is missing from an order, Medicare will disregard the order during the review of the claim. This means that your partners in health care who provide ancillary diagnostic and therapeutic services will not be paid for the care they provide unless there is a signed order in the medical record.

Overpayment Recovery

In the bill that was passed to avoid the consequences of going over the fiscal cliff, a provision was included stating that Health and Human Services (HHS) agencies will have the authority to recover overpayments going back five years as a way to increase dollars to the Treasury. This is up from the current three-year time frame. This change is based on recommendations from the HHS Office of Inspector General and is predicted to result in savings of $500 million.

Template Alert

The Center for Medicare and Medicaid Services (CMS) recently published an update to the Medicare Program Integrity Manual regarding the use of templates. The update is applicable to services rendered 12/10/12 and forward. The update states:

"Some templates provide limited options and/or space for the collection of information such as by using 'check boxes,' predefined answers, limited space to enter information, etc. CMS discourages the use of such templates. Claim review experience shows that limited space templates often fail to capture sufficient detailed clinical information to demonstrate that all coverage and coding requirements are met.

Physicians should be aware that templates designed to gather selected information focused primarily for reimbursement purposes are often insufficient to demonstrate that all coverage and coding requirements are met. This is often because these documents generally do not provide sufficient information to adequately show that the medical necessity criteria for the item/service are met.

If a physician chooses to use a template during the patient visit, CMS encourages them to select one that allows for a full and complete collection of information to demonstrate that the applicable coverage and coding criteria are met.

[Medicare] Review contractors shall remember that progress notes created with Limited Space Templates in the absence of other acceptable medical record entries do NOT constitute sufficient documentation of a face-to-face visit and medical examination."

While we expect faculty to use the efficiencies in EPIC such as templates and dot phrases, we encourage you to utilize the many free text options EPIC offers for sufficient personalized patient data capture. Use your department Clinical Practice Specialists as a resource to review these tools for compliance.
Source: CR 8033

Volume of Documentation Doesn't Determine Coding, Necessity Does

As our Medicare carriers begin to see the beefed-up documentation that EHRs allow, they may place restrictions or limitations on requirements to bill the higher-level E&Ms.

For instance, TrailBlazer (Medicare carrier for TX, OK, CO, and NM) has stated in "Documenting Components of an Established Office E&M Service": "Do not record unnecessary information solely to meet requirements of a higher-level service when the nature of the visit dictates a lower-level service to be medically appropriate". This mirrors national Medicare policy, which asserts, "It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The vol-

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ume of documentation should not be the primary influence upon which a specific level of service is billed" (CMS Transmittal 178, Change Request 2321, May 14, 2004).

With the EMR, we no longer need to worry about illegible documentation and we do not want to have to worry about records that are un-intelligible due to the carryover of vast amounts of irrelevant information.

In the News

Psychotherapy Hoax

A federal grand jury in Hartford returned a 27-count indictment recently charging Alan Emmett Bradley, 57, of Norwalk, Connecticut, and Ocoee, Florida, with health care fraud and identity theft offenses.

The indictment alleges that Bradley, a certified alcohol and drug abuse counselor, obtained the Medicaid identification numbers of various Medicaid clients and used the identification numbers to submit hundreds of claims to Connecticut's Department of Social Services. The claims alleged that Bradley performed 75- to 80-minute individual psychotherapy sessions to these Medicaid clients at his office in Norwalk. Hundreds of these counseling sessions did not occur; and, for many of them, Bradley was actually living and attending school in Florida.

The indictment charges Bradley with 12 counts of health care fraud, an offense that carries a maximum term of imprisonment of 10 years on each count, and 12 counts of making false statements relating to health care matters, an offense that carries a maximum term of imprisonment of five years on each count. Bradley is also charged with three counts of aggravated identity theft, an offense that carries a mandatory minimum term of imprisonment of two years, which must run consecutively to any sentence imposed on any other count of conviction. Source: FBI New Haven Office

Plainville Doctor Sentenced

Dr. Richard Luzietti pled guilty to two counts of illegally prescribing a controlled substance and one count of insurance fraud. Luzietti wrote more than 100 prescriptions for OxyContin and other controlled substances in the names of 33 people, many of whom he never met. In some cases, the drugs were returned to Dr. Luzietti who sold some and kept some for personal use. Some of the drugs were reimbursed by Medicaid. He was sentenced to eight years in prison suspended after four months, and five years of probation. Source: State of Connecticut Division of Criminal Justice

Hartford Oncologist Fined

The state Medical Examining Board fined a St. Francis Hospital Cancer Center oncologist $5,000 Tuesday for accidently administering 29 doses of radiation to the left side of a patient's mouth, when the cancerous mass was on the right side.

Dr. Richard C. Shumway signed a consent order with the state Medical Examining Board, agreeing to the fine and a reprimand.

In October 2006, a patient came to Shumway with a recurrent mass on the bottom right side of his mouth and Shumway recommended a course of radiation therapy directed at the mass and surrounding area. After 29 treatments, "it was discovered that the radiation therapy had been erroneously delivered to the left side of the patient's mouth, rather than the right side," the consent order with the state Department of Public Health (DPH) says.

The mistake was discovered when the patient asked why the left side of his mouth was sorer than the right side of his mouth, Tynan said. While Shumway doesn't personally administer the treatments, and "there are others who should have picked up this error," Tynan said, "Dr. Shumway is in charge."

DPH learned about the incident from Shumway's malpractice insurance carrier after a settlement was reached, said Fazzina. Source: CT Health I-Team

State Hospitals Face 2nd Highest Rate Of Federal Penalties Nationwide

Connecticut fared second-worst in the country in the percentage of hospitals hit with federal penalties for selected quality-of-care measures and in the overall rate of loss of Medicare reimbursements associated with those penalties, new federal data shows.

Eighty-six percent of the state's 30 acute-care hospitals were penalized under Medicare's Value-Based Purchasing Program, an incentive program created under the Affordable Care Act to reward hospitals on a number of quality measures related to treatment of patients with heart attack, heart failure, pneumonia and certain surgical issues, as well as patient satisfaction. Overall, the state's hospitals lost .15 percent of their Medicare reimbursement, compared to a .02 percent average loss nationally, the data shows.

In addition to the penalties on quality measures, 23 Connecticut hospitals lost Medicare funding because of high rates of readmitting patients within 30 days of a hospital stay. Four faced the maximum loss, a 1 percent reduction in funding: Griffin Hospital in Derby, the Hospital of St. Raphael, the Masonic Home and Hospital in Wallingford, and MidState Medical Center in Meriden.

Several hospitals fared well under the new system. Middlesex Hospital in Middletown received a .13 percent bonus on the quality measures and no readmissions penalty; Bridgeport, Danbury and St. Mary's Hospital in Waterbury also received small bonuses for quality.

Under the value-based program, hospitals receive penalties or incentives based on how well they perform on 12 clinical measures, such as controlling surgery patients' blood sugar levels or giving them antibiotics, and on eight patient experience measures, including how well doctors and nurses communicate with them and how clean and quiet the hospital is during their stays.

When penalties for quality and readmissions are combined, Yale-New Haven Hospital took the worst hit, losing 1.25 percent of its Medicare reimbursements, according to data compiled by Kaiser Health News. Following close behind were Johnson Memorial in Stafford Springs (a 1.16 percent loss) and St. Raphael's (a 1.12 percent loss). Source: CT Health I-Team

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