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IMPROVING MEDICAL RECORDS AND EFFICIENT CODING STRATEGIES

GARFUNKEL HEALTH ADVISORS, INC.

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OBJECTIVES

- Best Practices for Improving the Medical Record
- Key Strategies for Efficient Coding
- Important Takeaways
- Q&A

ABOUT US

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Alicia has over 36 years of clinical and administrative healthcare experience, specializing in documentation and coding, revenue cycle integrity, and a strong background in both voluntary and mandatory compliance program development and implementation.

She frequently works with business litigation and health law practices on fraud and abuse intervention teams and providing litigation support.

Alicia has presented educational and training seminars nationally on compliance, documentation and coding, and practice management. She is also a frequent author for online physician blogs and journals.

She is an Accredited Health Care Fraud Investigator (AHFI), and is certified in Healthcare Compliance (CHC, CPCO). She is a Certified Professional Coder (CPC), Certified Professional Medical Auditor (CPMA), certified in Risk Adjustment Coding (CRC), and a Certified Professional Practice Manager (CPPM).

Garfunkel Health Advisors, Inc. (GHA) is healthcare consulting company providing strategic and operational advice to the healthcare industry.

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Michelle has over 30 years of clinical and administrative healthcare experience, specializing in documentation audits, coding, credentialing, human resources, HIPAA Privacy & Security, revenue cycle integrity, and a strong background in both voluntary and mandatory compliance program developmentand implementation

She frequently works with business litigation and health law practices on fraud and abuse intervention teams and providing litigation support.

Michelle has presented educational and training seminars nationally on compliance, documentation, HIPAA Privacy & Security, human resources, coding, and practice management. She is also a frequentauthor for online physician blogs and journals.

She is a Certified Professional Coder (CPC), Certified Professional Medical Auditor (CPMA), Certified Professional Compliance Officer (CPCO), and a Senior Certified Professional SHRM-SCP.

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ASC MEDICAL RECORD REQUIREMENTS

- Medical records are legal documents and are subject to State and Federal laws
- Standard medical practice requires the ASC surgeon to systematically document the patient's medical record with information concerning the illness, injury or condition that brought the patient to the ASC, as well as the care and services received by the patient while at the ASC.
- Documentation must be complete, comprehensive, and accurate to ensure adequate patient care.
- The ASC must develop and maintain a system for the proper collection, storage, and use of patient records.

Note: Review state regulations for record retention requirements

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MEDICAL RECORDS - DOCUMENTATION COMPLIANCE

- There are multiple sources of regulation and oversight when it comes to documentation compliance including:
  - State Licensure Regulations
  - Medicare Conditions for Coverage (CfCs)
  - State Operating Manual
  - Accreditation Standards
  - Nationally Recognized Standards and Guidelines
  - Standards of Care
  - While not considered to be regulation, best practices should also be adopted when appropriate

Note: Items must be documented at varying frequency: there are daily, weekly, monthly, quarterly, annual, and variable requirements.

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§ 416.47 CONDITION FOR COVERAGE - MEDICAL RECORDS (CMS)

According to CMS cfc, the ASC **must**:

- Have a complete, comprehensive and accurate medical record for each patient
- Document timely
- Use the information contained in each medical record to assure that adequate care is delivered to patients
- Ensure the confidentiality of each patient's medical record

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§ 416.47 CONDITION FOR COVERAGE - MEDICAL RECORDS (CMS)

Each Patient must have a unique medical record.

Every record must be accurate, legible, and promptly completed. This is not an all-inclusive list however, based on the CFC criteria, medical records must include at least the following:

(1) Patient Identification

The identity of the patient must be clear through use of identifiers such as name, date of birth, social security number, etc.

(2) Significant Medical History and Results of Physical Examination (as applicable)

A medical history and physical assessment (H&P), completed as applicable and entered into the medical record in accordance with the requirements at §416.52, as well as the results of the pre-surgical assessments specified at §416.42 and §416.52.

§ 416.47 CONDITION FOR COVERAGE - MEDICAL RECORDS (CMS)

Medical records must include at least the following:

(3) Pre-operative Diagnostic Studies (entered before surgery), if performed

If pre-operative diagnostic studies were performed, they must be included in the medical record prior to the start of surgery.

(4) Findings and Techniques of the Operation, Including a Pathologist's Report on All Tissues Removed During Surgery, Except Those Exempted by the Governing Body

An operative report that describes the surgical techniques and findings. A pathologist's report on all tissues removed during surgery must also be included, unless the governing body has adopted a written policy exempting certain types of removed tissue from this requirement.

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§ 416.47 CONDITION FOR COVERAGE - MEDICAL RECORDS (CMS)

Medical records must include at least the following:

(5) Any Allergies and Abnormal Drug Reactions

The patient's history of allergies or abnormal drug reactions prior to the surgery, as well as any allergies or abnormal drug reactions that occurred during or after the surgery prior to discharge.

(6) Entries Related to Anesthesia Administration

Information related to the administration of anesthesia during the procedure and the patient's recovery from anesthesia after the procedure.

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§ 416.47 CONDITION FOR COVERAGE - MEDICAL RECORDS (CMS)

Medical records must include at least the following:

(7) Documentation of Properly Executed Informed Patient Consent

A well-designed informed consent process can be found in the interpretation guidance in the State Operations manual.

(8) Discharge Diagnosis

Documentation of the patient's discharge diagnosis. The record should also include the patient's disposition, i.e., whether the patient was discharged to home (including to a nursing home for patients already resident in a nursing home at the time of surgery), or transfer to another healthcare facility, including emergent transfers to a hospital.

Note: (Not to be confused with Standard Discharge instructions)

CMS SURVEY PROCEDURES: §416.47(B)

- The absence of any required element must be cited as Standard-Level non-compliance.
- The absence of a number of elements from a number of medical records might warrant citation of Condition-Level non-compliance.

The absence of one element from a number of medical records – e.g., lack of informed consent to surgery – should warrant citation of Condition-Level noncompliance.

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COMMON CITATION FINDING EXAMPLES

- No Documentation of Allergies or Adverse Reactions
- No Update Completed
- No Documentation of Pre- or Post-Procedural Calls to Patients
- Update Not Dated and Timed
- Update Completed Post-Operatively
- Reports Not Timely Signed
- No Medication Reconciliation

* (Data based on medical record consulting chart reviews)

ACTION ITEMS - MEDICAL RECORD COMPLIANCE STRATEGIES

- Risk Analysis
- Implementing Necessary Policies & Procedures
- Educating Providers and Staff
- Daily Monitoring
- Auditing for Effectiveness
- Corrective Actions
- Accountability
- Re-Education

POLICIES & PROCEDURES- MEDICAL RECORDS

- Keep Everyone on the Same Page
- Accessible and Shared with All Employees
- Update Annually or More Frequently, if Necessary
- Monitor for Effectiveness and Applicability
- Give Everyone an Opportunity to Ask Questions
- Require Attestations

Note: Do not have policies that you do not follow!

EDUCATION -MEDICAL RECORDS

- Communication is Essential to Avoiding Errors
- Annual and On-going Education
  - Staff
  - Providers
  - Others
- Test / Quiz for Understanding

AUDITING - MEDICAL RECORDS

Auditing is Critical to Determine Compliance & Effectiveness

- Identify and correct issues early
- Develop and implement corrective actions
- Get to the root cause of problems
- Identify outlier providers
- Create a process, set benchmarks and re- audit protocol
- Repeat the process frequently

AUDIT TOOLS - MEDICAL RECORDS

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Client Information

Date of Review:	
Patient ID#:	
Dates of Service Reviewed:	

#	Assessment	Yes / No	Findings	Recommendations/Guidelines	Internal Comments
1.	Patient information complete on face sheet.	☐ Yes ☐ No			
2.	Patient MR # present on face sheet.	☐ Yes ☐ No			
3.	Admission date noted.	☐ Yes ☐ No			
4.	Patients language or communication needs are documented	☐ Yes ☐ No			
5.	Sex of patient is documented.	☐ Yes ☐ No			
6.	Performing surgeon listed on face sheet	☐ Yes ☐ No			
7.	Spouse's, parent's or significant other's name and phone number documented. (if other than responsible party)	☐ Yes ☐ No			
8.	Patients were offered information on Advance Directives.	☐ Yes ☐ No			

SIGNATURE REQUIREMENTS

All services provided to beneficiaries are expected to be documented in the medical records at the time they are rendered.

All Medical Record Entries Must Include (among other things):

- The date of service, and
- A legible, dated, and timed signature of the provider.

Providers should not add late signatures to the medical record, other than those that result from the short delay that occurs during the transcription process.

Coding Strategies and Best Practices

ASC CODING STRATEGIES AND REVENUE CYCLE INTEGRITY

- Complex System for Reimbursement
- Use Trained and Experienced Professionals
- Similar Structure & Controls Apply to Coding and Revenue Cycle Compliance
  - Risk analysis
  - Policies & Procedures
  - Education
  - Audit
- Commercial plans may or may not follow CMS policy for ASC claim filing

Note: Check the carrier's site for information on claim filing and check your contract with the payer.

ASC CODING STRATEGIES AND REVENUE CYCLE INTEGRITY

When Submitting a Claim, the Following Questions are Answered:

Who? The provider who performed the service and the patient who received care.

What? CPT® and HCPCS Level II codes are reported to identify the services performed and supplies used.

Where? The location the services were rendered.

When? Date of service

Why? The reason the services were performed. ICD10-CM codes identify the diagnoses treated.

MEDICAL NECESSITY

One of the most important requirements to receive payment for services is to establish medical necessity. You must justify care provided by presenting the appropriate facts. Payers require the following information to determine the need for care:

1. Knowledge of the emergent nature or severity of the patient's complaint or condition.
2. All signs, symptoms, complaints, or background facts describing the reason for care.
3. The facts must be substantiated by the patient's medical record, and that record must be available to payers on request.

ASC CODING STRATEGIES AND REVENUE CYCLE INTEGRITY

Because payers have a contractual obligation to enrollees, they may request additional documentation to validate that services provided were:

- Appropriate to the treatment of the patient’s condition
- Medically necessary for the diagnosis and treatment of an illness or injury
- **Coded correctly**
- Reported correctly for the site of service

OPERATIVE REPORT CHECKLIST

Problems occur when dictation is incomplete or unclear. A three-hour surgery cannot be described adequately in two paragraphs.

A physician cannot rely on a staff coder or an insurance adjudicator to be aware of details and procedures that are not fully explained or included in the report.

Complete details and documentation make a decided difference in the coding and consequently, the correct reporting of any surgical procedure.

OPERATIVE REPORT CHECKLIST

Applying the following suggestions will help ensure accurate and correct reporting of procedures.

1. The **dictation should match the seriousness of the circumstances and procedures**. If there were extensive complications, the words extensive complications should be included in the report. The dictation should also **indicate what aspects of the procedure were unusual or complicated.** Was there abnormal anatomy? Were there extensive adhesions requiring surgery time longer than normal for lysis of adhesions? Words or phrases such as very difficult, complicated, unusual circumstances, extensive, and multiple, or ordinary, uncomplicated, and simple, help you verify the appropriate codes and modifiers to describe the service rendered. It is essential that the selected codes are validated by the operative report.

OPERATIVE REPORT CHECKLIST

2. Make sure the **modifiers used for outpatient hospital facilities are approved** for use in the facility setting. Keep in mind not all CPT® modifiers are used in the hospital outpatient setting.
3. The length **of time spent** on each procedure should be specified, especially if the time spent is of unusual duration
4. The **length of all repairs** should be specified. Note whether a repair is **simple, intermediate, or complex.**

The **layers of skin, subcutaneous tissue, down to the bone**, that are involved in a procedure should be documented. In some cases, the **depth of involvement** will determine the code selected for the procedure.

For **lesion excisions, specify the diameter of the lesion plus the smallest margin multiplied by two.**

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OPERATIVE REPORT CHECKLIST

5. Time spent in **prolonged attendance** should be documented
6. **Unusual circumstances** and the use of **special instruments** or aids, such as an operating microscope or fluoroscopic guidance, should be recorded.

   There are several modifiers to describe specific circumstances, such as the use of a surgical team or an assistant surgeon.

   The time spent using an operating microscope, fluoroscopic or ultrasonic guidance, or other special aids should also be documented.

KEY TAKEAWAYS

- Understand Federal, State and Accreditation Requirements
- Critical complete, accurate & timely documentation
- Submitting Claims with Appropriate Codes and Modifiers
- Beware of Bundling and Unbundling Services
- Implement controls and follow through on corrective actions
- Stay aware of industry changes!

REFERENCES

- https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_l_ambulatory.pdf
- https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-15-22.pdf

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THANK YOU FOR YOUR TIME TODAY

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