Codify by AAPC

Eli's Rehab Report

TPs Documenting E/M Exams? Read This First

Teaching physicians, take note: Don't rely on residents to complete your documentation for you. Your reimbursement hinges on complete documentation -yours and the resident's.

Last November, the Department of Health and Human Services released Medicare Transmittal 1780, which relaxed documentation requirements for E/M services that residents render and teaching physicians (TPs) bill. The new requirements do not, however, mean that teaching physiatrists can relax by simply stamping "Concur with resident" on every chart.

The new requirements allow physicians to document that they saw and evaluated the patient and that they agree or disagree with the resident's findings, says **Mike Lemanski, MD,** a physician at Baystate Medical Center, a large teaching hospital with an E/M residency program of 36 residents. In other words, "TPs do not need to repeat documentation already provided by the resident." In the past, TPs had to document the key elements of the E/M evaluation: the history, physical exam, and medical decision-making, Lemanski says.

Although physicians will benefit from these guidelines, you should be aware of some ambiguous documentation practices that could get your practice into hot water. First, make sure that your physicians meet the requirements stated directly in the transmittal (excerpted in "Know Your Teaching Physician Requirements").

Define the Exam's 'Key' Portion

CMS mandates that teaching physicians must only document "that they performed" or were "physically present" during the key portions of the E/M service. Despite the new documentation guidelines, however, TPs must still be directly present for "key" or "critical" portions of E/M exams, and must examine the patient and review and discuss the resident's plan of care.

The transmittal indicates that the TP should determine which portion of the exam he or she considers key or critical. "The guidelines clearly state that if the key portion cannot be defined, the teaching physician must be present for the entire service," says **Cindy C. Parman, CPC, CPC-H, RCC,** co-owner of Coding Strategies, Inc., a healthcare reimbursement consulting firm in Dallas, Ga. "Therefore, any 'key portion' requires a separate, specific, written definition."

This does not mean that the TP can breeze in during the key portion and leave the room immediately afterward. "The teaching physician is reimbursed for direct patient services and not for the teaching services provided to the resident/teaching facility," Parman says. "If the resident sees the patient, performs all elements of an E/M and documents his or her findings, the TP must review all data, discuss the information with the resident, repeat key portions (and list specifically what those are) and dictate his or her own note."

Don't Accept Shrinking Notes

Some PM&R practices report that their TPs' documentation shrinks a bit every month as they rely on the new documentation regulations to coast them through potential audits. The statement "I was present with the resident during history and exam. I discussed the case with the resident and agree with the findings and plan as documented in the resident's note" is now acceptable but could too easily be shortened in a busy hospital to "Discussed with resident. Agree." If you see TP documentation that states the latter, don't report the service until you have more documentation. CMS would not consider the shortened statement acceptable.

Inform your teaching physicians that when they perform E/M services, their documentation should demonstrate that they examined the patient (independently or with the resident), that they reviewed, discussed and agreed with the findings

CPT® 2023 American Medical Association. All rights reserved.

and plan of care, and note any exceptions or changes between the resident's documentation and the TP's.

Be sure to avoid rubber stamps with standard lines such as "Agree with above" or "Agree with resident," says **Eric Sandham, CPC,** compliance educator for Central California Faculty Medical Group, a group practice and training facility associated with the University of California at San Francisco.

Sandham suggests that TPs use the first-person and active voice to show that they participated in the patient management. Review the following two scenarios to ensure that you and your physicians share the same documentation expectations. After all, if you don't submit the correct documentation, you're not able to secure all of the money your practice deserves.

Scenario #1

Case: A resident sees a 68-year-old patient in the hospital's rehabilitation unit. The patient is rehabilitating from a recent left hip replacement and complains of an inability to move her left leg. The resident suspects that the prosthesis loosened or became dislocated, but upon examination he determines that the patient's thigh is slightly swollen and stiff. He advises the patient to stay off of the leg and elevate it until the swelling subsides. He recommends replacing the patient's standard gait-training therapy with a course of aquatic therapy. The teaching physician then examines the patient and confirms the resident's findings.

Documentation You Should Expect: "History: Refer to the resident note. The history was reviewed with both the resident and the patient, and I was present for the physical examination. I discussed the findings with the resident and agree that the patient has minor swelling and soreness due to overexertion during physical therapy. I agree that the patient requires rest and a switch from gait training to aquatic therapy for the next seven days."

The TP reports this service as a subsequent inpatient encounter (99231-99233).

Scenario #2

Case: The resident sees a 19-year-old man rehabilitating from foot amputation. The patient complains of severe pain in his calf. The resident examines the patient and diagnoses minor skin irritation at the amputation site. The TP then examines the patient and suspects deep venous thrombosis (DVT). He orders a duplex ultrasound study, which confirms DVT. In this case, the TP does not agree with the resident's assessment and plan.

Documentation You Should Expect: "History: Refer to the resident's note. The history was reviewed with both the resident and the patient, and I observed the resident as he performed the physical examination. I have reviewed and discussed the findings with the resident. I believe the patient has DVT, and I agree that the patient should continue his therapy, but I recommend a course of heparin and warfarin, along with regular blood-clot monitoring."

The TP should report the appropriate subsequent inpatient encounter code (99231-99233).

Residents' Notes Should Sparkle

Because the new regulations allow TPs to document less, residents' notes should be more thorough than ever before, Sandham says. "For example, a lack of family history could technically mean that you can report only level-one initial hospital care (99221) even if all other elements of the service are comprehensive."

Because the TP's reimbursement now relies on the resident's documentation, the TP should ensure that the resident documents the appropriate history, exam and medical decision-making elements.

CPT® 2023 American Medical Association. All rights reserved.