Health Information Compliance Alert

Guest Column: Take Medical Necessity Into Account While Completing Documentation

Transparency, clarity and relevance are essential.

You have to be wary while using your templates to ensure that your electronic medical records are not only compliant but also demonstrate the medical necessity for both the level of E/M as well as any service rendered, warn our experts. "With the introduction and now continued implementation of the Electronic Medical Record (EMR), it's more important than ever to make certain that the documentation supports the individual level of service for each patient being seen," **Suzan Berman, CPC, CEMC, CEDC** writes in this special article for **Eli**.

With the creation of templates, smart phrases, easy text, etc. the clinicians are able to document more compliant to the E/M documentation guidelines without taking medical necessity into account. This is troubling to the payers and should also be to the companies creating the records as well as the providers using them.

Educating everyone within the healthcare stream is vital. The technicians and programmers need to understand why the documentation is so important and how they should be incorporated into the electronic note. It is also imperative to have this understanding so that records can be created, stored, and maintained appropriately. Educating the office staff, support staff, medical personnel, and management encompasses why signatures, dates, demographics, and more are essential and how it all should be compliantly entered into the medical record. And certainly educating the physicians about why the specifics within the documentation are needed and the over-riding umbrella of medical necessity are the driving force of clinical documentation improvement plans, and more manageable electronic systems.

The Office of the Inspection General (OIG) just published a report (May, 2012) illustrating the shift in the curves of billed E/M service toward the higher levels. The report doesn't directly point to the increased use of EMRs; however, it's clear that with documentation capabilities being more robust there is a trend which the OIG is keenly aware of.

Details of the report show that between 2001 and 2010, Medicare increased the payment of E/M services, from $22.7 billion to $33.5 billion. E/M payments can range from $19 to $213 depending on the type of patient, the type of service, and the level of care provided. With this vast difference in payment, it is clear why this code set is a constant target of fraud, scrutiny and multiple interpretations of the guidelines.

The OIG launched this review from two perspectives. One was to look at the reimbursement based on the documentation. The other focused on the documentation mechanics (dictation, EMR, templates, forms, etc.)

The services they reviewed were from 2001 and 2010. Notably, the latter dates would have a larger sampling of electronically documented records. Although the review didn't target potential fraudulent activity, it did mention two health care organizations had to pay back over $10 million to settle allegations about fraudulent billing.

In the top three (3) categories reviewed, (Subsequent Hospital visits, Established patient visits, and Emergency Room services) the review found that, although the middle code (level 3 for the Established and Emergency services) was still the most often billed service, the higher levels of service are being billed higher.

The specialties billing the higher services more often were Family Practice, Emergency Medicine, and Internal Medicine with Obstetrics/Gynecology showing the largest percentage increase of those billing only the higher levels 4.3 percent as compared to their peers who are using all billing levels consistently at 1.9 percent.

Physicians who bill higher levels of service might say that they are seeing older patients, sicker patients, or patients with several comorbid conditions; however, the results of this study don't indicate this is the case. Their patients are around

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the same age, with the same diagnosis codes submitted, and the patients were no sicker than those seen by their peers billing all five levels of service.

As a result of this report, The Center for Medicare and Medicaid Services (CMS) as recommended by the OIG should continue to educate the physician community on the appropriate application of the documentation guidelines. This could include letters, in-person seminars, teleconferences, etc.

The Medicare Carriers will be reviewing more evaluation and management services (E/M) billed by physicians. With regard to the physicians who consistently bill higher levels of services as indicated in this report, those names will be provided to the carriers in those jurisdictions and depending on a cost/benefit analysis, there will be more extensive reviews done for those physicians.

The provider community could view this report as a call to order. Documentation is becoming more robust, more transparent amongst agencies and other providers, and it must be clear, clean, and relevant. It's imperative that the provider community make certain to put in place appropriate documentation improvement plans, and not just in preparation for ICD-10, but for cleaner claims, more appropriate billing, and clearer care plans that ultimately result in better outcomes for the patients.

Education to the clinicians should be continual and timely. Physicians should welcome the education and not feel overwhelmed, over-scrutinized, or threatened. Educators should be accommodating with where and when the education is done and understand the providers' perspective. They should develop their training tools for various ways to deliver the information. Meeting in small spans of times, taking a short break from patients or meeting early in the morning might be appropriate alternatives to more lengthy sessions. Weekend seminars and evening meetings with colleagues might also be great settings to provide billing and coding education. Webinars and teleconferences are also very productive ways to convey this information. The more the guidelines are reviewed, the easier they are to adapt into the patient visit flow.

EMRs are an amazing tool in the healthcare environment and when built and used properly will help the office flow, patient care, and the revenue stream. The higher levels of service might be appropriate levels of service, but the documentation must be there to substantiate not just the level of service, but also the medical necessity.

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