Medical Decision Making: Documentation of Complexity

OH/WV/SC
July 1, 2009
OBJECTIVES

- Overview of the Comprehensive Error Rate Testing Program (CERT)
- Identify general documentation principals
- Review the Medical Decision Making Component of an Evaluation & Management service
- Discuss documentation tips for Medical Decision Making
- Identify resources for CERT and Evaluation & Management Services
Comprehensive Error Rate Testing (CERT) Program
The Comprehensive Error Rate Testing Program

• The Comprehensive Error Rate Testing (CERT) program monitors and reports the accuracy of Medicare claims
  – Paid Claims Error Rate: dollars
  – Provider Compliance Error Rate: accuracy

• Most recent data: May 2008 CERT report

• CMS views these error rates as a measure of how well contractors communicate Medicare guidelines to providers and staff
CERT Paid Claims Error Rates for Palmetto GBA
May 2008 Report: 5 Highest Code Groups
Ohio and West Virginia

= All three of the three key components required

Palmetto GBA July 2009
CERT Paid Claims Error Rates for Palmetto GBA
May 2008 Report: 5 Highest Code Groups
South Carolina Part B

- Chiropractic services: 24.2%
- Consultations: 19.6%
- Hospital visits-subsequent: 12.1%
- Office visits-new: 11.6%
- Other tests: 9.3%

= All three of the three key components required
Reasons for Errors

• Most errors resulted from documentation supporting a lower level of service than the submitted code
• A few consultations were changed to “visits” (3 R’s)
• “3 of 3 key components” – required for initial hospital visits, consultations, and new patient office visits
Labs- Medical Necessity & Signatures

When medical records are requested for review of clinical laboratory tests rendered by an independent lab, the lab should submit the following:

1. Test results which show the billed service(s) were rendered, and
2. Any supporting documentation sent to the laboratory by the requesting provider
Labs- Medical Necessity & Signatures

Establishing medical necessity:

– Verify the ordering-treating provider’s involvement with requesting the patient’s tests.

The presence of a ‘signed’ (electronic or otherwise) order by the authorizing provider is often the simplest means by which to validate the tests performed and billed by an independent clinical laboratory.
General Documentation
Principles
General: Principles of Medical Record Documentation

- The medical record should be complete and legible
- Each patient encounter should include:
  - Reason for encounter and relevant history, physical examination findings, and prior diagnostic test results
  - Assessment, clinical impression, or diagnosis,
  - Plan for care
  - Date and legible identity of the observer
- If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred
- Past and present diagnoses should be accessible to the treating and/or consulting physician
- Appropriate health risk factors should be identified
- The patient’s progress, response to and changes in treatment, and revision of diagnosis should be documented
- The CPT and ICD-9-CM codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record
Medical Decision Making Component
COMPONENTS OF E&M SERVICES

CHIEF COMPLAINT

1. HISTORY COMPONENTS
   - HISTORY OF PRESENT ILLNESS (HPI)
   - REVIEW OF SYSTEMS (ROS)
   - PAST, FAMILY, SOCIAL HISTORY (PFSH)

2. PHYSICAL EXAMINATION

3. DECISION MAKING
   - DX/MGT OPTIONS
   - TYPE OF DATA
   - RISK ASSESSMENT

= SELECTION OF CPT CODE
**DECISION MAKING**

**DIAGNOSIS/MANAGEMENT OPTIONS**

**CUMULATIVE: MORE DATA ➔ GREATER COMPLEXITY**

<table>
<thead>
<tr>
<th>PROBLEM CATEGORIES</th>
<th>NUMBER</th>
<th>POINTS</th>
<th>SCORE</th>
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<tbody>
<tr>
<td>SELF-LIMITED OR MINOR STABLE, IMPROVING, OR WORSENING</td>
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<tr>
<td>ESTABLISHED DX/PROBLEM STABLE, IMPROVED</td>
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<td>ESTABLISHED DX/PROBLEM WORSENING</td>
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<td>NEW PROBLEM NO ADDITIONAL WORKUP PLANNED</td>
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<tr>
<td>NEW PROBLEM ADDITIONAL WORKUP PLANNED, CONSULTATION</td>
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</table>

**TOTAL**
Diagnosis/Management Options

Tips

• For a presenting problem with an established diagnosis the record should reflect whether the problem is: a) improved, well controlled, resolving or resolved or b) inadequately controlled, worsening or failing to change as expected.

• For a presenting problem without an established diagnosis, the assessment or clinical impression may be stated in the form of differential diagnoses or as a 'possible', 'probable' or 'rule out' (R/O) diagnosis.

• The initiation of, or changes in, treatment should be documented. Treatment includes a wide range of management options including patient instructions, nursing instructions, therapies and medications.

• If referrals are made, consultations requested or advice sought, the record should indicate to whom or where the referral or consultation is made or from whom the advice is requested.
Diagnosis/Management Options

Example

**DIAGNOSTIC DATA (From reports provided):**

Chem 7: Electrolytes within normal limits. BUN 18, creatinine 0.8, blood sugar 98, Liver profile: Within normal limits. Total bilirubin 0.5. Serum CO2 18. CBC: White blood cell count 2, hemoglobin 7, hematocrit 21, platelet count 98.

Differential: 53% segmented neutrophils, 27% lymphocytes, 13% monocytes, 0% bands. Amylase 96, lipase 1,127.

Urinalysis: Essentially negative. No evidence of ketones. All indices are otherwise negative.

Flat and upright x-ray of the abdomen which I independently reviewed: No free air, air/fluid levels, ileus or obstructions, unusual calcifications, gallstones, kidney stones. The patient does have a prominent liver and spleen shadow at this time. Normal bowel gas pattern. Independent review of chest x-ray: Negative. No infiltrates are seen. No pneumothorax. Cardiac silhouette within normal limits. No bony abnormalities to the chest wall.

**DIAGNOSES:**

Pancreatitis
Abdominal pain
Anemia
## DIAGNOSIS/MANAGEMENT OPTIONS

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<td>NEW PROBLEM ADDITIONAL WORKUP PLANNED</td>
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### DECISION MAKING

#### TYPE OF DATA

**CUMULATIVE: MORE DATA ➔ GREATER COMPLEXITY**

<table>
<thead>
<tr>
<th>POINTS</th>
<th>TYPE OF DATA</th>
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<tbody>
<tr>
<td>1</td>
<td>REVIEW &amp;/OR ORDER CLINICAL LAB TESTS</td>
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<td>1</td>
<td>REVIEW &amp;/OR ORDER TESTS IN CPT 7xxxxx SERIES</td>
</tr>
<tr>
<td>1</td>
<td>REVIEW &amp;/OR ORDER TESTS IN CPT 9xxxxx SERIES</td>
</tr>
<tr>
<td>1</td>
<td>DISCUSS TEST RESULTS WITH PERFORMING PHYSICIAN</td>
</tr>
<tr>
<td>2</td>
<td>INDEPENDENT REVIEW OF IMAGE, TRACING, OR SPECIMEN</td>
</tr>
<tr>
<td>1</td>
<td>DECISION TO OBTAIN OLD RECORDS, &amp;/OR HISTORY FROM OTHERS</td>
</tr>
<tr>
<td>2</td>
<td>REVIEW &amp; SUMMARIZE OLD RECORDS &amp;/OR HISTORY OBTAINED FROM OTHERS</td>
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</tbody>
</table>

**TOTAL**

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Type of Data Tips

- If a diagnostic service (test or procedure) is ordered, planned, scheduled or performed at the time of the E/M encounter, the type of service, e.g., lab or x-ray, should be documented.
- The review of lab, radiology and/or other diagnostic tests should be documented. A simple notation such as 'WBC elevated' or 'chest x-ray unremarkable' is acceptable. Alternatively, the review may be documented by initialing and dating the report containing the test results.
- A decision to obtain old records or decision to obtain additional history from the family, caretaker or other source to supplement that obtained from the patient should be documented.
- Relevant findings from the review of old records, and/or the receipt of additional history from the family, caretaker or other source to supplement that obtained from the patient should be documented. If there is no relevant information beyond that already obtained, that fact should be documented. A notation of 'Old records reviewed' or 'Additional history obtained from family' without elaboration is insufficient.
- The results of discussion of laboratory, radiology or other diagnostic tests with the physician who performed or interpreted the study should be documented.
- The direct visualization and independent interpretation of an image, tracing or specimen previously or subsequently interpreted by another physician should be documented.
**Type of Data Example**

**DIAGNOSTIC DATA (From reports provided):**

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<td>4</td>
<td>TOTAL</td>
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</table>
## DECISION MAKING

### TABLE OF RISK

<table>
<thead>
<tr>
<th>LEVEL OF RISK</th>
<th>PRESENTING PROBLEM(S)</th>
<th>DIAGNOSTIC PROCEDURES</th>
<th>MANAGEMENT OPTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>MINIMAL</td>
<td>1 SELF LIMITED</td>
<td>LABS, XRAYS, EKG/EEG, U/A, U/S, MRI NO CONTRAST</td>
<td>SUPERFICIAL DRSGS</td>
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<tr>
<td>LOW</td>
<td>1 STABLE CHRONIC ILLNESS</td>
<td>LABS - ARTERIAL PUNCTURE, MRI WITH CONTRAST</td>
<td>OTC MEDS</td>
</tr>
<tr>
<td>MODERATE</td>
<td>1 OR MORE CHRONIC ILLNESS WITH MILD EXACERBATION</td>
<td>FLUID FROM BODY CAVITY</td>
<td>RX MEDS</td>
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<tr>
<td>HIGH</td>
<td>1 OR MORE CHRONIC ILLNESS WITH SEVERE EXACERBATION</td>
<td>CARDIOVASC. IMAGING STUDIES WITH CONTRAST &amp; I.D. RISK FACTORS</td>
<td>PARENTERAL CONTROLLED MEDS, MEDS REQ.INTENSE MONITORING, DNR DECISION</td>
</tr>
</tbody>
</table>

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### Decision Making

#### Risk Assessment

**Rating: Higher Risk ➔ Greater Complexity**

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<thead>
<tr>
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<th>Minimal</th>
<th>Low</th>
<th>Moderate</th>
<th>High</th>
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<tbody>
<tr>
<td>Diagnostic Procedures</td>
<td>Minimal</td>
<td>Low</td>
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</tr>
<tr>
<td>Management Options</td>
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<td>Low</td>
<td>Moderate</td>
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</tr>
<tr>
<td>Overall Risk</td>
<td>Minimal</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
</tr>
</tbody>
</table>

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Table of Risk
Tips

• Comorbidities/underlying diseases or other factors that increase the complexity of medical decision making by increasing the risk of complications, morbidity and/or mortality should be documented.

• If a surgical or invasive diagnostic procedure is ordered, planned or scheduled at the time of the E/M encounter, the type of procedure, e.g., laparoscopy, should be documented.

• If a surgical or invasive diagnostic procedure is performed at the time of the E/M encounter, the specific procedure should be documented.

• The referral for or decision to perform a surgical or invasive diagnostic procedure on an urgent basis should be documented or implied.
Table of Risk
Example

**DIAGNOSTIC DATA (From reports provided):** Chem 7: Electrolytes within normal limits. BUN 18, creatinine 0.8, blood sugar 98, Liver profile: Within normal limits. Total bilirubin 0.5. Serum C02 18. CBC: White blood cell count 2, hemoglobin 7, hematocrit 21, platelet count 98. Differential: 53% segmented neutrophils, 27% lymphocytes, 13% monocytes, 0% bands. Amylase 96, lipase 1,127. Urinalysis: Essentially negative. No evidence of ketones. All indices are otherwise negative. Flat and upright x-ray of the abdomen: No free air, air/fluid levels, ileus or obstructions, unusual calcifications, gallstones, kidney stones. The patient does have a prominent liver and spleen shadow at this time. Normal bowel gas pattern. Chest x-ray: Negative. No infiltrates are seen. No pneumothorax. Cardiac silhouette within normal limits. No bony abnormalities to the chest wall.

**PROCEDURES:** The patient received intravenous hydration, Phenergan for nausea, Reglan for abdominal cramping, Protonix for antacid. The patient tolerated the procedure well. Rested comfortably. Had no further complaints.

**CONSULTATION:** Case discussed with M.D. who is aware of the patient’s presentation, current signs, symptoms, physical examination, recent evaluation at _______ Hospital and need for further admission and transfusion for anemia. Agreed to admit the patient to _______ Hospital. The patient is clinically stable at this time.

**DIAGNOSIS:**
- Pancreatitis
- Abdominal pain
- Anemia

**PLAN:**
Admit to _______ Hospital per family M.D. Orders have been reviewed. The patient will be direct admission. The patient is clinically stable in no acute distress.
# RISK ASSESSMENT

<table>
<thead>
<tr>
<th>Presenting Problem(s)</th>
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<td>Diagnostic Procedures</td>
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</tr>
<tr>
<td>Management Options</td>
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<td>Low</td>
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## TYPE(COMPLEXITY) OF DECISION MAKING

**RATING:** HIGHER SCORE ➔ GREATER COMPLEXITY

<table>
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<tr>
<th>DIAGNOSIS/MANAGEMENT OPTIONS</th>
<th>1 = MINIMAL</th>
<th>2 = LOW</th>
<th>3 = MODERATE</th>
<th>4 = HIGH</th>
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<tbody>
<tr>
<td>TYPE OF DATA</td>
<td>≤1 = MINIMAL</td>
<td>2 = LOW</td>
<td>3 = MODERATE</td>
<td>4 = HIGH</td>
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<td>OVERALL RISK</td>
<td>1 = MINIMAL</td>
<td>2 = LOW</td>
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<td>4 = HIGH</td>
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## TYPE (COMPLEXITY) OF DECISION MAKING

<table>
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<tr>
<th>Diagnosis/Management Options</th>
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<td>4 Extensive</td>
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Resources

• [www.cms.hhs.gov/manuals/IOM/list.asp](http://www.cms.hhs.gov/manuals/IOM/list.asp)
  – Pub.100-04 Chapter 12
  – Pub.100-08 Chapter 3

• Current Procedural Terminology CPT 2009

• [www.palmettogba.com/boh/guide](http://www.palmettogba.com/boh/guide) for OH
  [www.palmettogba.com/bsc/guide](http://www.palmettogba.com/bsc/guide) for SC
  [www.palmettogba.com/bwv/guide](http://www.palmettogba.com/bwv/guide) for WV
  – Physician Supplier Guide
    • Evaluation and Management Guidelines
    • Specialty Articles

• [www.cms.hhs.gov/cert](http://www.cms.hhs.gov/cert)
  – Overview; and
  – CERT reports

• [www.palmettogba.com/cert](http://www.palmettogba.com/cert)
  – Graphs by specialty
  – Example letters