



Update on the “Newest” Version of the E & M Documentation Guidelines

The Centers for Medicare and Medicaid Services (CMS - formerly known as HCFA) recently announced that the draft 2000 E & M guidelines will be put on hold. The newest guidelines were developed to simplify the documentation process by minimizing counting requirements for the physical examination component. In addition, the examination and medical decision making components would use vignette examples to assist the provider in determining a level. CMS contracted with Aspen Systems to develop the clinical examples/vignettes for use with the 2000 guidelines.



Since the release of the new guidelines and vignettes, the reaction from the AMA and medical specialty associations has not been favorable. In a letter dated June 28, 2001, the AMA requested that a task force be established to examine the guidelines. The AMA asked for an extension of the comment period and a reassessment of the need for the vignettes. As stated in this letter, “the guidelines were not relevant to typical physician-patient encounters, were inconsistent, used clinical language that is seldom used in physician medical records, and exclude major patient groups the specialty was most likely to be treating.” The most recent development occurred this past July when HHS Secretary Tommy Thompson ordered Aspen Systems to stop its work. There were few details released about how CMS would proceed.

Documentation Pointers- Timelines and Addenda

In the world of instant-messaging and instant-relays, do any of us really expect less than instant-access to documentation? Frequently the Compliance Office is asked, “How long do I have to generate a note?” or “What do you mean my notes need to be legible!” Our office has always encouraged providers to document the visit in a timely fashion, but recently CIGNA Medicare published documentation pointers which detail important timeframes for providers in their monthly bulletin.

- Medicare expects the documentation to be generated during the time of service or shortly thereafter.
- Delayed entries within a reasonable time frame (24-48 hrs) are acceptable for purposes of clarification, error correction, the addition of information not initially available, and if certain unusual circumstances prevented the generation of the note at the time of service.
- The medical record cannot be altered. Errors must be legibly corrected so that the reviewer can draw an inference as to their origin. These corrections or additions must be dated, preferably timed, and legibly signed or initialed.
- Every note stands alone; i.e. the performed services must be documented at the outset.
- Delayed written explanations will be considered for purposes of clarification only. They **cannot be used to add and authenticate services billed and not**





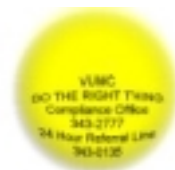
documented at the time of service or to retrospectively substantiate medical necessity. For that, the medical record must stand on its own with the original entry corroborating that the service was rendered and was medically necessary.

- All entries must be legible to another reader to a degree that a meaningful review can be conducted.
- All notes should be dated, preferably timed, and signed by the author.
- In the office setting, initials are acceptable as long as they clearly identify the author.

- If the signature is not legible and does not identify the author, a printed version should also be recorded.

Standards of Conduct Update

The VUMC Standards of Conduct brochure is being revised. The revised document will combine medical center specific standards with university standards and there will be a single document for all Vanderbilt employees. In addition, we are in the process of changing the SOC video and will include scenarios highlighting current issues that affect university and medical center faculty and staff. After the final revisions are made to the brochure and video, employees will be asked to participate in a brief session and will receive updated information and materials.



If you have any questions regarding the standards of conduct, please contact the medical center compliance office at 343-2777.

Did You Know That Free Patient Care Equipment Can Be a Problem?

No one should accept loaned or free equipment from a vendor if it obligates the patient to purchase supplies or reagents from that vendor in order to use the equipment. For example: Company A offers to provide our patients with free glucose monitors. In order to use the monitor, the patient must purchase strips that are manufactured and sold by Company A. It is important to recognize that if a vendor is offering a free service there may be strings attached which can result in compliance issues. Questions related to these types of arrangements should be directed to the Compliance Office at 343-2777.

Billing News

• Liver Transplant Coverage Expanded

Beginning September 1, 2001, Medicare will cover adult liver transplants for liver cancer patients with the following conditions:

1. The patient isn't a candidate for a subtotal liver resection;
2. The patient's tumor is less than or equal to 5 cm in diameter;
3. There is no macrovascular involvement;
4. There is no identifiable extrahepatic spread of tumor to surrounding lymph nodes, lungs, abdominal organs or bone; and
5. The transplant is done at an approved liver transplant facility.

Since 1999, Medicare has only covered liver transplants when performed on patients with end stage liver disease other than malignancies. For more detail see transmittal 142 of the Coverage Issues Manual.



- **HCFA Changes Its Name**



The Health Care Financing Administration (HCFA) was legally renamed the Centers for Medicare and Medicaid Services or CMS.

- **Medicare Enrollment Process Improvements**

Medicare Part B Carriers now have 60 days to process your provider enrollment application. The old instructions gave Carriers 45 days but the clock stopped whenever the form was returned due to errors. Under the new instructions, the Carrier has 60 days regardless of changes that have to be made to the forms. Also, under the new guidelines, the Carrier must review the entire application before returning it for corrections. For additional information please see transmittal #7 of the Medicare Program Integrity Manual.

- **New Modifiers**

Effective January 1, 2002 the GX modifier will be deleted and replaced with 2 new modifiers. (The GX modifier is used for services that are billed to Medicare when the provider knows the service is not covered but wishes to receive a denial. Patients sometimes request a denial from Medicare in order to bill their private insurance.)

Two new modifiers have replaced the GX modifier:

GY – Used when a service is statutorily excluded (i.e. preventive exam) or does not meet the definition of any Medicare benefit. A waiver or ABN is not necessary.

GZ – Used when a service is expected to be denied as not reasonable and necessary. A waiver or ABN is not required.

Use of the GA modifier remains the same. It is used when a provider expects a denial and they have obtained a waiver or ABN from the patient.

OIG 2002 Work Plan

The Office of Inspector General has posted its work plan for the 2002 fiscal year. The work plan is a compilation of the areas the OIG will focus on during the next fiscal year.

Some of the areas affecting hospitals include the following:

- Medicare Payment Error Prevention Program (PEPP)
- Medical Education Payments
- One-Day Hospital Stays
- Uncollected Beneficiary Deductibles and Co-insurance
- Outpatient Prospective Payment System

Areas affecting physicians include the following:

- Advance Beneficiary Notices
- Physicians at Teaching Hospitals (PATH)
- Evaluation and Management Coding
- Inpatient Dialysis Services
- Bone Density

The complete work plan can be reviewed by going to the OIG web site at www.dhhs.gov/progorg/