Table of Contents

1 Code New and Established E & M Codes Correctly

Per 2012 CPT book: “A new patient is one who has not received any professional services from the physician or other physician of the same specialty and who belongs to the same group practice, within the past three years”. Please note that this rule does not specify billing but professional services only.

You would choose 9920x codes if:
1. Patient is requesting second opinion (3-year rule applies)
2. Physician from different specialty transfers care to you (3-year rule applies) and is not asking for your opinion, consult. For example, ED Attending who has different specialty from yours provides services to the patient and requests follow up care in the outpatient clinic.

“An established patient is one who has received professional services from the physician or another physician of the same specialty and who belongs to the same group practice, within past three years”.

You would choose 9921x codes if:
1. Patient was seen in VU Spring Hill clinic by Internal Medicine Physician during March 2009 and Internal Medicine Physician at VUMC Hillsboro Group provided service on February 2012. Hillsboro Group physician would choose to bill 9921x category code if evaluation and management service provided.
2. Patient received service by the Orthopedic Resident in the VUMC ED and follows up with Orthopedic Attending in the outpatient clinic, this scenario would generate 9921x code for the Orthopedic Attending.

Please note that effective April 2nd, 2012, two new physician specialties codes: Sleep Medicine (C0) and Sports Medicine (23) were created by CMS and they will be recognized as valid primary and/or secondary specialty codes. 

(CMS Manual System Pub 100-04 Medicare Claims Processing, transmittal 2462).
Appropriate Authentication  
submitted by Joy Carr

The new scrutiny regarding signature requirements is a hot topic of discussion these days. In a CMS newsletter *MLN Matters, Signature Guidelines for Medical Review Purposes – JA6698*, they try to clarify how providers can ensure they meet the signature requirements that Medicare review contractors follow. This is a technical issue that outside reviewers can easily put focus on, because if the requirements are not met, there is nothing to appeal. Thus it saves time and revenue.

Providers can authenticate their documentation by using a written or electronic signature. However, it is **never** appropriate to use a signature stamp.

ACs (Affiliated Contractors), MACs (Medicare Administrative Contractors), PSCs (Program Safeguard Contractors), ZPICs (Zone Program Integrity Contractors), and CERTs (Comprehensive Error Rate Testing Contractors) will be looking for the following in regards to handwritten signatures:

- **Illegibility** – The reviewer has the choice of whether or not a signature log or attestation statement will be allowed to confirm the identity of the provider.
- **Orders with Missing Signatures** – The order will be considered invalid by the reviewer.
- **Additional Medical Documentation with Missing Signatures** – The reviewer will consider accepting a signature attestation which must be from the author of the documentation.

On page 12 of the following link, [http://www.cms.gov/Transmittals/downloads/R327PI.pdf](http://www.cms.gov/Transmittals/downloads/R327PI.pdf), you will see a list of sixteen scenarios that determines whether or not those scenarios meet the handwritten signature requirements or require follow up attestations.

In regards to electronic signatures, the system in place needs to ensure documentation by a provider does not allow change once it is authenticated. Addendums and attestations that allow separate signatures are acceptable. A reviewer may ask about the security of the electronic medical record in order to prove documents cannot be altered after completion.

In addition the Conditions of Participation states, “All entries in the medical record must be dated, timed, and authenticated, in written or electronic form, by the person responsible for providing or evaluating the service provided.”

Vanderbilt policies related to authentication can be found at the links below:

**Medical Record Completion and Authentication:**
[https://mcapps.mc.vanderbilt.edu/E-Manual/Hpolicy.nsf/AllDocs/77CA5B89B9CD7BBE86256BE40066EC09](https://mcapps.mc.vanderbilt.edu/E-Manual/Hpolicy.nsf/AllDocs/77CA5B89B9CD7BBE86256BE40066EC09)

**General Guidelines for Inpatient & Outpatient Medical Record Documentation:**

**Electronic Signature Policy:**
[https://mcapps.mc.vanderbilt.edu/E-Manual/Hpolicy.nsf/AllDocs/AE153E71754DF01F86257914004C353C](https://mcapps.mc.vanderbilt.edu/E-Manual/Hpolicy.nsf/AllDocs/AE153E71754DF01F86257914004C353C)

**Could You Be Accused of Cloning**  
Submitted by Tina Gleadall

Along with the creation of the electronic medical records, a whole new set of problems for outside payors exists. Below are some examples:

The documentation is certainly legible; however, the payors are having a difficult
time trying to determine which portions of the medical record are being pulled from the past record and what the present interval problem that is currently being treatment.

In order to educate and protect our Vanderbilt physicians/providers from being accused of “Cloning” there is an actual Vanderbilt policy which instructs in detail the proper way to document the medical record to avoid allegations of cloning. If you go to the Vanderbilt University Medical Center website and click Resources for Employees, you can gain access to the VUMC Policy Manual. You will need to log in with your VUNET username and password. If you sort by category, you will come across the Carry Forward of Clinical Information in the Electronic Health Record, Policy Number OP 10-40.41

The most important portions of this policy is to understand that any “previously documented information that is carried forward, imported, or supplied by use of a template must be reviewed and edited to remove all information that does not accurately reflect the services provided during the encounter being documented and to add any missing information pertinent to the current encounter.”

“Using Carry Forward to insert entire sections or reports from documentation found elsewhere in the medical record is discouraged. If done, such information should be limited to only currently pertinent and clinically relevant information. More documentation is not necessarily better documentation. Creating an unnecessarily long note by carrying forward previously charted documentation that is not pertinent to the current encounter is discouraged, in that it only makes it difficult for the reader to find relevant information.”

In layman’s terms, when it is necessary to pull forward documentation from a previous record be sure to edit it appropriately. A common error seen in audits is the following example “Cindy Lou Hoo presents a 6 year old, here today with complaints of an ear ache. Mom says that she has been pulling at her ears for 3 days and is starting to run a low fever with a runny nose.” In time this same patient may develop chronic earaches, which may eventually require putting tubes in the ears. Therefore, it may be appropriate to pull that past note forward to follow the pathology of the illness.

But if you pull it forward you need to edit the note appropriately. If you just copy and paste the note as written, you could be accused of cloning, if you do not edit correctly. If two years had passed since that note was written, the child’s age would have changed. Editing accordingly “Cindy Lou Hoo originally presented as a 6 year old with complaints of an earache.” While adding further visit documentation could be useful to determine why the decision for a tympanostomy tube placement would be appropriate for this patient.

Please be sure to separate this past history by at least one line and then add the “Interval History” or what is going on with the patient on the present day of service.

Another common misconception may be found in the exam templates. It is quite possible to have an exam to look similar or even identical for several visits in a row. However, outside payors may suspect the template finding as cloning unless you actually affix a statement and signature by the author that verifies that there has been little or no change since the previous visit. This is required by Vanderbilt’s Carry Forward policy prior to final approval of the documentation.

“Documentation in the medical record is audited for compliance with VUMC policies, as well as, CMS and other regulatory requirements”.

References:
https://mcapps.mc.vanderbilt.edu/E-Manual/Hpolicy.nsf/AllDocs/77CA5B89B9CD7BBE86256BE40066EC09
https://mcapps.mc.vanderbilt.edu/E-Manual/Hpolicy.nsf/AllDocs/GC3EF13404510E2C86256BE3006A2B96
Documentation Is Only Required for Billing

Submitted by Shelly Lampley

As an auditor, I hear this statement a lot but the reality of it is you can bill what you want; however, it doesn’t mean you will get paid. We work a lot off of templates and you can set up your template to always bill a certain level of care (three, four or five E/M services), but if it is not relevant and you are always excessively adding documentation just to bill certain levels of service, it can send up red flags to the payers.

In these tough economic times you must believe that our insurance carriers are analyzing our business and if we are routinely billing E/M services just for “billing” purposes, we are bound to be making costly errors. Documentation does not have to be lengthy - just relevant and to the point of what is going on with that patient today. It is our jobs as compliance consultants to provide feedback whenever we are looking at a provider’s documentation and assist them in how to improve what they are documenting. Although the rules are frequently changing, this is an area in which we make harder than it really needs to be. Simply document the facts and specifically state the medical necessity for why certain tests are needed and then bill for what is documented, don’t document just to bill.

Coder Compliance at Vanderbilt is a useful tool to assist providers, billing coordinators and managers in correct coding and billing processes. We research your questions and provide solid feedback from authoritative sources so please utilize our service when in doubt or if you are going to be billing for a new service in your area, let us assist with correct documentation guidance. Coder.compliance@vanderbilt.edu

VU Creates Hotline to report Fraud, Waste and Abuse

Submitted by Fernando Murphy

The new combined University and Medical Center hotline and website for anonymously reporting fraud, waste and abuse was launched on Friday, March 8th.

Faculty and staff can use the Integrity in Action reporting network to report unethical, illegal or unsafe activity at Vanderbilt. The website — www.inwgrc.com/Vanderbilt — and toll free number — (866) 783-2287 — are available 24 hours a day, seven days a week. You do not have to give your name, although you might be asked to check back to provide additional information or to answer questions.

Existing procedures will also remain in place for those wishing to report complaints through a supervisor, or to the office charged with ensuring compliance with a particular policy.

Reports involving allegations of harassment and or discrimination that fall within the University and Medical Center non-discrimination and anti-harassment policy should be reported directly to the Equal Opportunity Office.

Thousands of brochures and posters were disseminated campus-wide to publicize the new reporting network.

Submit any questions or comments to: Compliance.office@vanderbilt.edu