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The Insider News

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DWC Adjusts Fee Schedule to Conform with Medicare Technical Fix

The California Division of Workers' Compensation posted an adjustment to the outpatient hospital departments and ambulatory surgical centers section of the Official Medical Fee Schedule, effective March 1.

The amendments conform to changes in the Medicare payment system as required by Labor Code section 5307.1, the DWC said.

The change to California Code of Regulations section 9789.31 will conform to the Centers for Medicare and Medicaid Services' (CMS) 2009 hospital outpatient prospective payment system correction notice to a final rule of Nov. 18, 2008, published on Jan. 26 in the Federal Register. CMS' correction notice fixes technical errors that appeared in the CMS final rule published in the Federal Register, the DWC said.

The changes supersede an adjustment to 9789.31 made by the order of the acting administrative director dated Jan. 26. The adjustments can be found at: http://www.dir.ca.gov/DWC/OMFS9904.htm.

Reminder: Red Flag Rules

Don't Forget! The deadline for compliance with the Red Flag Rules is May 1, 2009.

The Red Flag Rules are federal legislation from the FTC (Federal Trade Commission) mandating that all entities who are "creditors" have an identity theft prevention and detection program in place.

Are you a "creditor"? Under the current FTC definition, the answer is probably "yes". The FTC believes that physicians extend credit by allowing deferred payment, either by waiting until insurance payments are made, or by allowing the patient to pay a balance over time.

To comply with the requirements, you must have in place policies and procedures to identify, protect and respond to identity theft "red flags".

Enforcement is through the FTC and fines can be up to $2,500 per occurrence for each "knowing violation".

E/M Coding: History

This is the first in a series of three articles that talks about the key components in E/M Coding.

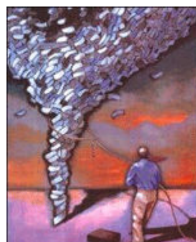
The "History" in Evaluation and Management Coding consists of four elements:

- Chief Complaint
- History of Present Illness
- System Review
- Past, Family, and Social History

Coding Tips for History Documentation:

- Always document the chief complaint. If it's a follow-up visit or medication check, indicate the conditions being reviewed. This helps to support visit complexity.
- $\geq$4 HPI are required for upper level codes. Not all visits are upper level codes, but a minimum of 4 HPI is usually gathered by the provider, it just doesn't always get documented to that extent.
- If you are coding based on 1997 guidelines, an alternative to $\geq$4 HPI is the status of 3 chronic conditions. Other history requirements (CC, ROS & PFSH) still apply.
- HPI must be documented at each encounter by the provider. It can't be referenced from information documented by the staff or from previous encounters.
- The information counted toward the system review can't be the same information as is counted toward the HPI. For example, if you count "nausea" as the HPI element associated sign and symptom, you can't also count it as system review.
- ROS and PFSH can be recorded by someone other than the provider (i.e., staff member or the patient or patient's family), but there must be documentation that the provider has reviewed and agreed with or amended the information provided.
- The ROS or PFSH from an earlier encounter can be referenced, but any changes must be noted and the date and location of the previous information must be documented (i.e., ROS from my note 2/12/09 unchanged).
- If you are a consultant reviewing records from a referring PCP, you can reference ROS and PFSH from that document as well (i.e., ROS and PFSH as recorded in Dr. Smith's note of 3/12/09 unchanged except that the patient's is now experiencing increased numbness in the right leg).
- Remember that if your note is requested for audit, all referenced documents must be included as well.
- Conversely, the inclusion of additional information intended for referencing won't "count" unless your chart note actually documents that fact.
- CPT defines one element of "past history" as the patient's current medications. Inclusion of the med list or documentation that the med list is reviewed and updated as appropriate (give date and location of referenced med list) will support 1 PFSH requirement.

Industry News



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For coding questions, contact Gladys Ross, CPC, CCS-P, ACS-EM at gross@grmed.com.

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