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EHR: Be Careful of “Cloning”

Physicians expect the EHR to provide documentation efficiencies. Some of these efficiencies include copy/paste opportunities, short-cut options (click a button and get a negative system review or exam), etc. While these are certainly useful, they must be applied with caution. Remember that the prime requirement of each encounter is medical necessity, and that documentation for each encounter must be specific to both the patient and the encounter.

Medicare actively reviews provider documentation for what it calls “cloning”. “Cloning” is essentially the presence of repetitive verbatim information from note to note or patient to patient. One example of cloning might be a generic system review repeated for every patient, regardless of the patient’s presenting problem. Another might be the inclusion of “click-button” entire negative system review – that contradicts positive information documented in the patient’s history.

The following is part of a statement originally released by Medicare through several of the Medicare intermediaries:

“Cloned documentation does not meet medical necessity requirements for coverage of services rendered due to the lack of specific, individual information. All documentation in the medical record must be specific to the patient and her/his situation at the time of the encounter. Cloning of documentation is considered a misrepresentation of the medical necessity requirement for coverage of services. Identification of this type of documentation will lead to denial of services for lack of medical necessity and recoupment of all overpayments made.”

Certainly there is some information that may be repetitive from note to note. But the information in each patient’s note must be applicable and relevant to the patient and representative of the encounter. Each time these available short cuts are applied, the user must review the documentation produced for accuracy and relevance.

E/M Coding: The Exam

Editors Note: This is a continuation of our series to cover the key components of E/M coding.

Based on Medicare rules, there are two available sets of examination guidelines. The first is the 1995 guidelines, and the second is 1997. Both are acceptable, and Medicare states that “whichever is more advantageous to the provider” may be used.

The 1995 guidelines determine the level of the exam based the extent of the evaluation of body areas and organ systems. The 1997 guidelines determine the level of exam based on the number of documented “bullet points”.

The primary problem with the 1995 guidelines is that the lack of specificity between an expanded problem focused and a detailed exam. Most groups who employ the 1995 guidelines use the following standard:

- Problem Focused: 1 body area/organ system
- Expanded Problem Focused: 2-4 body areas/ organ systems

- Detailed: 5-7 body areas/organ systems
- Comprehensive: 8 organ systems

The list of body areas and organ systems is listed in CPT in the Evaluation and Management Guidelines

Some Tips for Using 1995 Guidelines:

- Remember that the comprehensive level exam is organ systems only – not body areas.
- When determining the exam level, count either body areas or organ systems, but not both within the same encounter.
- There is one variance between the CMS 1995 guidelines and CPT. CPT does not list the Constitutional system as an exam system. The CMS 1995 guidelines do recognize the Constitutional System.

The 1997 guidelines consist of a series of examination examples developed by CMS. There is one general multi-system exam, and a series of single system exams. The single system exam are usually used by specialists. The general multi-system exam is used by primary care and specialties for which there is not a specific single system exam (i.e., gastroenterology).

Benefits to the 1997 exam is that coding is less subjective than the 1995 exam. When a “bullet point” is documented, it’s clearly documented, and there is no controversy over an exam level. Most auditors will confirm that it is easier to defend the level of an exam in an audit when using the 1997 guidelines rather than the 1995 guidelines.

Some Tips for Using 1997 Guidelines:

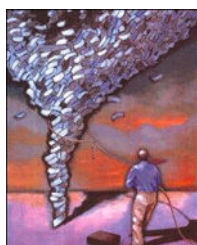
- Documentation must be specific. If the exam for the ENT system is limited to “ENT negative”, no bullet point credit is given because none are specifically identified.
- To get bullet point credit for vital signs, 3 vital signs must be documented. This must be from the list of what CMS defines as acceptable for vital signs. Some providers consider BMI or pain scale as vital signs – CMS does not.
- Exams cannot be mixed and matched within the same encounter. If using the general multi-system exam, you can’t incorporate the single system eye exam.

While both guidelines are available, most organizations adopt only one as a standard. Following a single set of guidelines is easier for the providers. Internally, it is simpler to teach and support one set of guidelines. The decision about which set to follow is often based on the specialty. For example, the single system Orthopedic exam listed in the 1997 guidelines is so complex that it is difficult to achieve an upper level code. As a result, many orthopedic groups adopt 1995 exam guideline instead.

Countdown: Key Dates

08/01/09:	Red Flag Rules take effect
01/10:	CMS expects to release the final list of EHR systems approved for stimulus money
2011	Largest amount of stimulus money available for groups using an EHR by 2011-2012 in a meaningful way
01/01/12	Deadline to transition to the new transaction system 5010
01/01/12	CMS implements penalty if not e-prescribing by this date
10/01/13	Implementation of ICD-10
2015	Penalties begin for providers not using EHR in a meaningful way

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