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The Business of Medicine

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AUDITING

Squaring clinician and auditor perspectives on documenting history

When evaluating medical record documentation to identify specific elements of history including the history of present illness (HPI) and the review of systems (ROS), auditors frequently rely on an audit tool or form to "check off" specific elements as they are identified in the record. They are then able to use this information as part of an education and feedback session to assist providers to understand potential deficiencies in medical record documentation in comparison to a reported Evaluation & Management (E/M) code.

At times, however, providers respond as though the auditor is using criteria outside the scope of what a healthcare practitioner should be capturing in their documentation. The reality is that auditors measure elements of HPI and ROS according to the same clinical documentation specifications that medical students are taught early in their journey to become clinicians. The *Bates' Guide to Physical Examination and History Taking,* authored by Barbara Bates and first released in 1974, has been published in several revised editions and has become a standard text for healthcare practitioners and medical students. The Bates Guide clearly identifies the exact same components of chief complaint, HPI and ROS that auditors look for in assessing the extent of a documented medical history.

Comprehensive documentation of the elements of history understandably becomes more concise as clinicians become proficient and familiar with the clinical method. However, it's important to note, concise should not be misconstrued as incomplete and the documentation of relevant elements of chief complaint (CC), HPI and ROS should be consistent with the patient's needs, the provider's goals for the assessment, the clinical setting (office or hospital) and the amount of time available. The extent of the HPI and ROS documented is entirely dependent upon clinical judgment and

(continued on pg. 2)

the nature of the presenting problem. Corresponding E/M codes reflect the amount of work performed and documented in obtaining the history including the history of present illness and review of systems. Auditors use the stated requirements for history including the HPI and ROS for each level of the E/M service to determine the appropriate level of code supported by the clinical documentation.

Breaking down the pieces

The **chief complaint** is the first thing we'll cover. Clinicians are taught the chief complaint or reason for visit must be captured in the patient's own words. While this is generally the most optimal format, there will be situations when a patient is uncertain or vague about their reason for visit. An example of this is a patient who presents stating that they are "here for test results". The provider must recognize this does not support a valid reason for services but instead should document the medical condition that prompted the test or tests to be performed.

The **History of Present Illness** (HPI) is next. This should be a complete, clear, and chronologic account of the problems prompting the patient to seek medical care. According to Bates, the HPI should contain factors including the problems onset, the setting in which it has developed, its manifestations, and any treatment. There are several broad questions which are applicable to any complaint. Medical students may be taught a mnemonic for the eight dimensions of a medical problem which can be easily recalled using OLD CARTS (Onset, Location/radiation, Duration, Character, Aggravating factors, Relieving factors, Timing and Severity). These attributes of every symptom are the same elements auditors use in assessing the extent of the documentation of HPI. In fact, auditors have the option to include one further aspect, the status of three (or more) chronic illnesses or conditions. This additional aspect of HPI can be helpful in identifying a HPI for well-established patients seen at regular intervals and who are without specific acute complaints identified in the above dimensions.

There are two levels of HPI:

- Brief HPI: Requires one to three HPI elements.
- Extended HPI: Requires four HPI elements or the status of three chronic problems.

The Review of Systems (ROS) is the third and final piece we'll examine here. For clinicians, the review of systems or symptoms is a list of questions, generally arranged by organ system, designed to identify clinical symptoms the patient may have overlooked or

forgotten. Ideally, the review of systems is designed to elicit information which the patient may not consider important enough to mention to the physician but that may identify additional conditions to be evaluated. The extent of information obtained through the review of systems may impact the extent of the physical exam performed and the corresponding assessment and plan of care. There are no specific rules regarding how much information must be asked about each system; this is generally left to the discretion of the clinician. The CPT manual as well as the CMS E/M Documentation Guidelines specifically identifies 14 individual body systems the clinician may inquire about.

Furthermore, there are three recognized levels of review of systems as recognized by the coding guidelines utilized by auditors.

- Problem Pertinent ROS: Review of *one* system related to current problem(s)
- Extended ROS: Review of *two to nine* systems
- Complete ROS: Review of ***at least*** 10 systems

Healthcare providers should understand professional medical auditors have not created new or unfamiliar criteria by which they evaluate the content and extent of documentation to assess conformance with a level of service. The specific details of documentation for HPI and ROS are based on the same structured framework for organizing patient information they were taught as students.

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MEDICARE RULES

CMS extends meaningful use hardship deadline to July 1

Now you have until July 1 to submit your application for a hardship exemption from meaningful use (MU) penalties in 2017, thanks to a recent, unexpected move by CMS. The agency announced that it was extending the hardship submission deadline from March 15 to July 1, 2016.

This gives you plenty of time to apply for the exemption, and you can even apply for the exemption if you believe that your providers were successful in attesting to stage 2 measures for 2015, a CMS official writes in an email to *The Business of Medicine*.

Note: The agency has already updated the PDF application form, so that it has a submission deadline date of July 1 instead of the original March 15. You can access the updated form here.

New deadline, same process

Some practices were confused about whether the extended deadline changes applications that are submitted after March 15. However, nothing is changing about the actual hardship application process other than the more generous deadline, the CMS official says.

Just as before, if providers believe they were affected by late CMS rulemaking that altered measures and reverted the reporting period from 365 days to a 90-day period for 2015,

they should choose "2.2.d" – EHR Certification/Vendor Issues (CEHRT Issues) – as the reason for their hardship, the CMS official says.

Successful attestation overrides exemption

Some AAOE member practices are submitting a hardship exemption even though their providers did attest in 2015, as a kind of safety net in case their attestations are not accepted for whatever reason.

It's safe to do so, and there is no scenario in which you will be given the exemption and not the incentive payment if you happen to qualify for the payment. "The two are not connected," the CMS official says. "A hardship does not negate the payment of an incentive."

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REVENUE CYCLE MANAGEMENT

6 ways to boost your practice's revenue

The revenue cycle is the backbone of all medical entities. Without a strong revenue cycle management (RCM) team, an organization can quickly fall apart financially. Most private practices can't survive a month without a steady flow of incoming cash. The question is, how do practices ensure that claims go out in a reasonable time and cash flow is stable?

1. Identify key financial performance indicators and measure them monthly on a dashboard that has at least 12 months of this data. The most important metrics that your RCM team should have are as follows: Total A/R per physician, percentage of total accounts receivable broken down by 30, 60, 90, and 120+ days outstanding, and adjusted fee-for-service collection percentage. Tracking A/R is crucial for any practice because every day that a claim sits in A/R is a day in which the practice loses half of a percent of possible collections. The organization loses this much when you factor in overhead and the cost of continually working these claims.

2. Retain an experienced coder with at least five years of experience, including billing experience. Medical billing is not a data entry position and is the last line of defense against intentional fraud and inadvertent overbilling. It is imperative that a coder reviews the documentation before claims go out. We have seen so many practices where physicians will just mark a sheet and the staff mechanically bill whatever is marked. Physicians are not billers and many, if not most, physicians lack a detailed understanding of coding concepts such as modifiers, bundling, add-on codes, and E/M level selection.

3. Maintain a system of checks and balances within your RCM department. A biller/coder or A/R follow-up representative should not have access to your software's payment posting module. Separate team members should handle payment posting so there is no conflict of interest. We have seen billers and individuals who handle A/R write off hundreds of thousands of dollars that should have never been written off. A payment poster checks and balances a biller/coder.

4. Ensure solid eligibility verification. The most important person with respect to RCM is the individual that works the front desk. In most practices this is where patients' insurance is verified and all the demographics are entered into the billing software. If this information is wrong, claims will not go out clean.

5. Proactively collect copays and deductibles before the patient is seen. Many patients are on high-deductible plans with deductibles of $5,000 or more, a trend that has increased since the passage of the Affordable Care Act. This has increased the amount of money in patient A/R, and the chance of collecting this amount is small. Ensure all patients' insurance is verified the day before the patient arrives and check their copay and deductible. Patients who have not met their deductible should be notified of how much they will be projected to pay before being treated.

6. Coordinate work on A/R. So many software programs now have siloed modules that individuals work out of in handling A/R. Although this can be efficient, it can leave out a very important piece of information. When an individual completes something in a module or moves it to a follow-up status, there is no way to observe A/R trending. Most clients have five to 10 issues with the entire A/R and, if those can be identified quickly, revenue

will increase. We advise all of our RCM clients to export their outstanding A/R into an Excel spreadsheet. Billers can then create a notes section and work the A/R using the spreadsheet. This information should be stored in a secure, HIPAA-compliant location so your practice administrator can review and track progress.

Finally, ensure your physicians know the team members doing your billing. Schedule team meetings with them together to review your financial report, which you can easily create in Excel. Establish a write-off process that requires the physician to sign off on a slip before money is written off for timely filing. This type of engagement between physicians and billers creates accountability and keeps physicians informed on how the practice is performing financially.

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CODING

ICD-10 denials: Encounter type and unspecified codes

It's been five months since ICD-10-CM diagnosis codes became mandatory on claim forms submitted to all payers by all HIPAA-covered entities, and for the most part denials remain low.

Acting CMS Director Andy Slavitt recently declared the ICD-10 transition an unqualified success, citing claims data that shows denials were actually *lower* in the last quarter of 2015 – immediately following the ICD-10 deadline – than the average historical baseline. "With preparation, planning, a focus on the customer, collaboration, clear accountability, and metrics, the dire Y2K fears didn't come to pass," writes Slavitt on his official CMS blog, referring to the fear that older digital systems would glitch when the year 2000 hit. "Instead, ICD-10 became like what actually occurred on Y2K, an implementation and transition most people never heard about," Slavitt writes.

While the CMS data shows that denials have indeed been low, there has been a recent uptick in denials that are due to problems with encounter types (initial, subsequent, or sequelae) and the use of unspecified codes (which end with the digit "9").

Encounter types

There have been only seven claims with ICD-10 errors since October 2015 at Children's Orthopaedic and Scoliosis Surgery Associates, LLP, says practice manager Debra L. Mitchell, RN, BSN, MBA.

The highly specialized pediatric orthopedic practice, located in St. Petersburg, Fla., had one erroneous claim due to the wrong ICD-10 code being selected by a new physician assistant, a simple one-off error, Mitchell says. The other six cases were due to the wrong encounter type being assigned to codes, and were all easily fixed.

"We have an EMR that has very good code search features, we trained the physicians on them, and we have a billing scrubber," Mitchell says. Obvious errors are caught before claims can go out the door.

Remember: The concept of encounter types in ICD-10 is similar to the idea of initial and subsequent hospital care services, which are described using E/M codes. ICD-10 adds a third concept, "sequelae," which covers the period from subsequent treatment once the condition is healed. Encounter types are indicated by the seventh character, "A" for initial, "D" for subsequent, and "S" for sequelae.

Encounter types are fairly straightforward, but there is a wrinkle in the ICD-10 definition of initial vs. subsequent. ICD-10 guidelines state that "A" is used to indicate an initial encounter "while the patient is receiving active treatment for the injury. Examples of active treatment are: surgical treatment, emergency department encounter, and evaluation and treatment by a new physician."

Initial *doesn't always* mean "the first time" the patient gets treatment for a procedure. Let's look a clinical example.
Example: A 32-year-old male patient is seen in the emergency department for a displaced transverse fracture of the right femur. Comfort care is provided and the leg is immobilized and iced. This encounter would be reported using S72.321A (displaced transverse fracture of the right ulna, initial encounter for closed fracture).

The next day, an orthopedic surgeon follows up to reduce the fracture – this care represents the patient's first active treatment for the fracture, since comfort care is not considered active treatment. Thus S72.321A is reported again.

A more typical scenario: If this patient was seen in the emergency department with a right femur fracture that was managed with active treatment right away, say with a cast. This emergency department visit would be coded as an initial encounter. When the orthopaedic surgeon follows up later, most likely in the office, he or she would report subsequent encounter because the fracture had received active treatment already.

Unspecified codes

In the original run-up to ICD-10, before the most recent one-year delay, CMS warned against relying on the use of unspecified ICD-10 codes, saying that they would be denied if regularly used. Now that practices are in the middle of CMS' much-publicized one-year grace period, during which Medicare carriers are under orders not to deny codes due to a lack of specificity, those initial warnings seem distant.

However, some practices have seen denials on claims recently where unspecified codes were used repeatedly. CMS allows and supports unspecified diagnosis codes in situations where "when such codes most accurately reflect what is known about the patient's condition at the time of that particular encounter."

In terms of new information needed for ICD-10, fractures are a particularly good example of how the amount of information required from the provider has grown.

Take a look at the additional specificity required for fractures:

1. Fracture type (e.g. open, closed, pathological, neoplastic disease, stress)
2. Fracture pattern (e.g. comminuted, oblique, segmental, spiral, transverse)
3. Etiology to document in the external cause codes
4. Encounter type (initial, subsequent, sequelae)
5. Healing status, if subsequent encounter (e.g. normal healing, delayed healing, non-union, mal-union)
6. Localization (e.g. shaft, head, neck, distal, proximal, styloid)
7. Displacement (e.g. displaced vs. non-displaced)
8. Classification (e.g. Gustilo-Anderson, Salter-Harris)
9. Any complications, whether acute or delayed (e.g., direct result of trauma sustained)

In our above example of the patient who suffers a fractured femur, we used code S72.321A, which covers all of the points above to as much detail as is required for this type of fracture. However, imagine if the we had submitted code **S72.90** (unspecified fracture of unspecified femur) – if this code were used repeatedly, it would soon trigger a payer response because it would be obvious to the payer that no practice should be routinely ignorant of the fracture type, pattern, and location for multiple patients.

Handling this level of detail is actually a strong point for most EHR systems, Mitchell says. Prior to the ICD-10 deadline, she presented her providers with a slide presentation explaining the need for more information, along with screenshots of how to dig for the precise ICD-10 codes using their EHR system. The result is that her providers know to search for the most exact diagnosis code before the encounter note goes to billing.

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HUMAN RESOURCES

10 tips for writing your employee handbook

Why have an employee handbook? One common mistake by some doctors is failing to realize the need for welldefined practice policies. Too often, doctors simply allow practice policies to evolve. Policies and procedures created on an ad hoc basis can lead to confusion, chaos and, sometimes, claims of discrimination or wrongful termination. If that happens, it can be a costly and timeconsuming experience.

Moreover, with the increase in wrongful termination litigation, the need for well-drafted personnel policies

is more crucial than ever in defending against private law suits and government agency charges. Ill-conceived policies create confusion between the employer and employee, and can even provide strong evidence for plaintiffs in wrongful termination litigation (the sword). By contrast, an up-to-date, well-crafted employee handbook explaining the practice's policies will reduce confusion and often provide effective evidence in defense of the employer (the shield).

A handbook can serve to effectively communicate practice policy, reinforce notice of specific laws, serve as written evidence of a practice's expectations, and be a valuable orientation and training document.

Each medical practice is unique, and one of the biggest mistakes employers make is to print a generic employee handbook from the Internet. Practices should consider developing a handbook that includes policies specifically customized to the practice's size and state.

The decision whether or not to use written personnel policies has always been more an issue of management style than an issue of legal requirements. However, a number of state and federal regulations passed in recent years require written personnel policies and/or postings on particular subjects. This is a growing trend and many practices who have not published personnel policies in the past are now being forced to address the issue. Personnel policies do not have to be assembled in a manual, but this is the most common format. Make the employee handbook and updates accessible to all employees and have each employee sign an acknowledgement form.

An employer that has not reviewed its personnel policies in recent years should do so and seek the advice of legal or human resources experts for assistance in updating their policies. Practices creating a handbook for the first time should carefully consider the structure and policies to incorporate into the handbook.

Here are some steps to consider when creating or updating your employee handbook:

1. Disclaimers. Employee handbooks should include a disclaimer that nothing in the handbook creates a contract for employment or alters the employee's at-will employment relationship. Handbooks also should include a disclaimer that the handbook cannot address every situation that could possibly arise in the workplace, so that the employer has flexibility in addressing unique situations.

2. Changes to federal and state law. Just as a practice grows and changes, so do federal and state laws, so employee handbooks should be updated annually to reflect these changes. If your handbook does not include the latest policies, it is out of date.

3. Email, social media and technology policies. Today it is important for an employer to outline social media and technology expectations. Employers should explain how to use electronic communications and employees should be notified if the practice plans to monitor computers and phones. Although it is important for employers to outline best practices for social media, practices should not be overly restrictive. For example, no practice wants employees to bad-mouth it on social media. However, a prohibition against any employee speech that could reflect negatively on the practice or physicians may violate employees' rights under Section 7 of the National Labor Relations Act. Employees also have the right to discuss wages and other work issues with fellow employees without reprisal.

4. At-will statements. Employment in most states is "at-will," which means that either the employee or the employer can choose to end the employment relationship at any time, with or without cause or notice. However, if the employee handbook does not clearly indicate this important status at the beginning , it can create problems. Outlining at-will employment expectations in your handbook will help clear up any confusion about the nature of employment and potentially prevent costly litigation.

5. Family Medical Leave Act (FMLA). Employers with 50 or more employees must grant an eligible employee up to a total of 12 work weeks of unpaid leave during any 12-month period under certain circumstances. It is important to properly outline employee eligibility requirements, procedures and guidelines for when the employee returns to the workplace to make the transition well organized for both the employer and employee. FMLA regulations changed in 2010. If your handbook has not been revised since then, your FMLA policy is out of date.

6. Overtime, vacation and sick time. It is also important for employers to clearly outline benefits and

attendance policies in the workplace. The employee handbook should address which employees are eligible for overtime pay and the internal process for approval of overtime. It is also important to stipulate that excessive absences or tardiness is grounds for termination to avoid any ambiguity with the employee.

7. Discipline in the workplace. Handbook policies should list the type of conduct that may result in employee discipline and potential penalties for infractions up to and including termination of employment. However, the handbook should not include a rigid "step" disciplinary system from which the practice cannot deviate, which would leave the practice ill-equipped to handle serious incidents if it is the employee's first infraction. Disciplinary policies should always include the disclaimer that the practice reserves the right to skip one or more steps as necessary, depending on the severity of the infraction.

8. Anti-harassment and discrimination policies. Not only is it vital that employers make it clear that no unlawful harassment will be tolerated in the workplace environment, but they should also clearly outline avenues for employees to report complaints of harassment or misconduct. Employees who have witnessed or experienced harassment should know there would be no retaliation for reporting complaints in good faith.

9. Keep your employee handbook user-friendly. Maintain a concise document, free of both ambiguity and overly legalistic language.

10. Apply policies consistently. Enforce the policies in your handbook the same way with every employee, every time. Inconsistent enforcement can have a negative effect on morale. It can also reduce the importance of your employee handbook if it appears that the policies do not really guide how employees are treated. Even worse, it can subject the practice to a claim of discrimination if the practice disciplines employees differently for the same infraction.

There is a lot to consider when implementing or updating an employee handbook. Addressing this matter in 2016 is a perfect way to review policies new and old. When done the right way, it will be a valuable tool and sets your practice in the right direction.

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