TUMG Documentation

Top 10

This education is One of Three General Compliance Education Presentations available on the Tulane University School of Medicine website:
http://tulane.edu/counsel/upco/billing-ed

- The other general compliance education presentations are:
  - Fraud and Abuse
  - Overview of Health Care Law

Physicians and Staff may earn one (1) compliance credit during a fiscal year (July 1 – June 30) upon completion of the assessment (attached).

To check how many compliance credits you have, and to see which training sessions you have completed, contact the University Privacy and Contracting Office at 504-988-7739

It is the policy of TUMG to provide healthcare services that are in compliance with all state and federal laws governing its operations and consistent with the highest standards of business and professional ethics. Education for all TUMG physicians is an essential step in ensuring the ongoing success of compliance efforts.
**TUMG Documentation Top 10**

10. **Know what doesn’t count when it comes to documenting service**
   - Outpatient visit documentation must stand alone.
   - Physicians cannot link to other visits for chief complaint, HPI or exam.
   - Only information documented in the visit note will count as support for a level of service.

9. **Link to Ancillary Staff notes and patient questionnaires.**
   - Staff notes and patient questionnaires can provide documentation that help to support a level of service, but physicians must link to them.
   - Medical students cannot document an E/M service.
   - If using a patient questionnaire to support a service, physicians should review, sign and date the form.

8. **Link to Resident Notes**
   - Linking to residents’ notes means that the level of service for the visit can be determined and supported by the combination of both the physician and resident notes.
   - Not linking to resident note will result in the level of service being determined by the teaching physician’s note alone.
     - If the resident note contains the history for a new patient, and the teaching physician does not link to the resident note or redocument the history, a new patient level of service could not be billed for the service.

7. **Read Resident Notes Before Linking**
   - When physicians link to resident notes, they attest that they have “reviewed” the documentation. The combined notes will determine the level of service.
   - For example, if you are counting on residents to document the history for a new patient you must link to the resident’s notes for the history to be counted.

6. **Code Signs & Symptoms if a Definitive Diagnosis Cannot Be Made**
   - ICD-9 Coding Guidelines state: “codes that describe symptoms and signs, as opposed to diagnoses, are accepted for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the physician.”
   - Rule out and possible conditions SHOULD NOT be coded. However, they may be mentioned in the visit note as support for the complexity of the medical decision making.

5. **Always Code to the Highest Specificity**
   - ICD-9 Coding Guidelines state: “A diagnosis code is invalid if it has not been coded to the full number of digits required for that code.”
   - The IDX Transaction Editing System (TES) is set up to suspend charges where codes are missing 4th or 5th digits.
4. **Avoid “Cloned” Notes**
- Cloned notes, or notes that have little or no change from visit to visit and patient to patient, raise both documentation and reimbursement issues.
- These types of notes do not support medical necessity. In some cases, they may not support that a visit actually occurred.
- Cloned notes may be construed as an attempt to defraud the Medicare program.

3. **Know How to Document a Time-Based Code**
   Time-based codes require two elements of documentation:
   - Two ‘times’ must be documented:
     - Total time of the visit
     - Amount of time spent face to face counseling with the patient and/or family - which must represent more than 50% of the total time
   - Content of counseling must be documented:
     - Counseling must be patient-specific
     - “Canned” notes are discouraged
     - Counseling must support medical necessity

2. **Understand and appropriately apply E/M Documentation Guidelines**
The Tulane Compliance Training Website has several presentations/handouts that address E/M Documentation.

   Visit the Tulane Website: [http://tulane.edu/counsel/upco/billing-ed/](http://tulane.edu/counsel/upco/billing-ed/)

1. **WYSI-WIG Principle**
- What You See Is What You Get
- If it isn’t written, it wasn’t done, and it can’t be billed.
- In the case of an audit, documentation that does not support medical necessity or the level of service billed may result in refunds and/or penalties.
Documentation Top 10 Quiz

NAME ___________________________      DATE _____________________
DEPT ___________________________  SIGNATURE _____________________________

1) A physician uses a patient questionnaire to obtain information regarding Chief Complaint, Review of Systems and Past/Family/Social History. The questionnaire has no place for physician signature or a date.  Top 10 Rule# _____________________

2) A physician and the resident see a patient at different times. The physician dictates a note but does not link to the resident note.  Top 10 Rule# __________________________

3) Referring to question 2, can the resident’s note be combined with the supervising physician’s note to support the level of service? (circle)  Yes  No

4) A diagnosis code is invalid if it has not been coded to __________________________________

5) To bill a time based code, what two elements must be documented in the medical record?
   a) __________________________________
   b) __________________________________

6) A physician dictates notes that are repetitive (reflecting little or no change in content), non-patient specific, and do not clearly support medical necessity. Top 10 Rule # ___________________

7) Understanding what elements must be documented for the History Component of an E/M services falls under what Top 10 Rule? _____________________________

8) What two elements, according to the WYSSI-WIG Principle, must be supported by the Medical Record documentation?
   a) __________________________________
   b) __________________________________

9) Outpatient documentation must stand alone. What Top 10 Rule addresses this documentation issue?
   __________________________________

10) Rule out codes and “possible” diagnoses should not be coded. What Top 10 Rule applies?
    __________________________________

Signature: __________________________________________

To receive one compliance credit: Complete quiz, be sure to print name (must be legible), the date, and your department at the top of the form.

SIGN the form (no credit will be given without a signature)
Fax to 504-988-7777 (fax information at top of form, no cover sheet required)