Documentation Best Practice to Support Coding and Billing

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Thursday, November 18, 2021

Disclaimer: *This presentation is offered as guidance to NEPHO providers and office administration. If you are a BILH employed practice please follow up with your practice Leadership on guidance reviewed during this presentation.*

Agenda

- What Should Drive Provider Encounter Documentation (MEAT)
  - **M**-monitoring
  - **E**-evaluating
  - **A**-assessing
  - **T**-treatment
- Documentation Supports Medical Necessity
  - Medical Necessity Overview
- Best Documentation Practice
  - Be Sensitive
  - If It Isn’t Documented it Did Not Happen
  - Documentation Supports Coding and Billing
- Documentation Examples
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  - Depression & Anxiety
  - Social Determinates Of Health (SDOH)
- Resources

M.E.A.T: Monitor, Evaluate, Assess, Treat

These four factors help providers establish the presence of a diagnosis during an encounter and ensure proper documentation.

- Simply listing every diagnosis in the medical record does not support a reported HCC code and is not accepted by CMS (Medicare). Documentation must support evaluation and treatment for each condition that is captured as an ICD-10 CM.
- **M.E.A.T is an acronym for:**
  - M: Monitor—signs, symptoms, disease progression, disease regression
  - E: Evaluate—test results, medication effectiveness, response to treatment
  - A: Assess/Address—ordering tests, discussion, review records, counseling
  - T: Treat—medications, therapies, other modalities

Supporting M.E.A.T

- Document each patient encounter as if it is the only encounter.
- Codes should be assigned for every condition documented in the chart note that has evidence of MEAT, not just the condition for which the patient came in.
- All chronic and complex conditions need to be coded annually.
- Review and document conditions managed by a specialist.
- When seeing a patient who comes in infrequently, ensure that chronic conditions are reviewed at the visit, even if they are only presenting for an acute issue.
- When refills are made outside of a visit, encourage patient to schedule a check-up so that the condition can be reviewed and managed at least once a year.
- Review and update the patient's active problem list at each visit. If a condition is no longer active, either remove it from the list or add "history of".
- Specify the basis for ordering additional testing/treatment.
- Show patient's progress or lack of progress .
- Avoid using the words "history of" for a condition that is chronic but currently stable, such as COPD, Diabetes, or atrial fibrillation.

Examples of M.E.A.T

- A condition can be coded when documentation states that the condition affects the care, treatment, or management of the patient. This must be documented and cannot be assumed.
  - **Example**: Sugar free cough syrup prescribed due to Type 2 DM
- Medication changes and the condition being treated need to be documented
  - **Example**: Major Depressive Disorder (MDD)-increase Paxil to 50 mg/day
- Conditions can be coded when documentation states condition is being monitored and treated by a specialist.
  - **Example**: Patient on Coumadin for A-fib followed by Cardiology

Diagnosis Supported by Documentation

Diagnosis:	Documentation Example:
Congestive Heart Failure (CHF)	Will continue same dose of Lasix and ACE inhibitor
Abdominal Aortic Aneurysm (AAA)	Abdominal ultrasound ordered
Major Depression Disorder (MDD)	Feelings of hopelessness despite increase in Zoloft. Will Refer to psychiatrist for further evaluation and management
Diabetes Type II w/hyperglycemia	Patient has uncontrolled Type II diabetes. They take insulin on a daily basis.
Morbid Obesity	Advised patient to monitor calorie intake and increase physical activity
Ulcerative Colitis	Discussed diet and foods to avoid and to help reduce flare up during holiday season

Medical Necessity Defined

- **Medical Necessity Overview:**
  - America College of Medical Quality:
    - Medical necessity is defined as accepted health care services and supplies provided by health care entities, appropriate to the evaluation and treatment of a disease, condition, illness or injury and consistent with the applicable standard of care.
  - America Medical Association (AMA):
    - In accordance with the generally accepted standard of medical practice.
    - Clinically appropriate in terms of frequency, type, extent, site and duration.
    - Not for the intended for the economic benefit of the health plan or purchaser or the convenience of the patient, physician or other health care provider.

Tips to Document Medical Necessity

- Identify a specific medical reason or focus for the visit (e.g., worsening or new symptoms).
- Document the rationale for ordering tests or referrals.
- Describe how the patient/caregiver has managed chronic conditions from the previous visit to present or explain acute symptoms; status of three chronic conditions may be used for History of Present Illness (HPI) credit.
- Include within the assessment and plan the provider's clinical impression, condition status, and treatment plan for each diagnosis assessed that day.
- Summarize the patient's health (e.g., improved, worsening, not responding as expected) and document services performed, treatments recommended, medication management, education/counseling, and goals of care conversations.
- Represent the patient complexity, overall patient risk level, and any aggregating factors or psychosocial challenges.
- Document initiation of, or changes in, treatment.
- Include patient and nursing instructions, therapies, and medications.

Be Sensitive Documenting Patient Conditions

- Patients must feel that a provider is empathetic and does not judge them. This is key not only to discussing weight, but to any subject that comes up. Providers should always try to give honest, straightforward answers and make patients feel at ease.
- A providers should build a relationship based on trust with their patient as this will help support honest conversations that will capture a patients true health status.
- Sensitivity will help drive positive patient experience and health outcomes.
- Speak honestly and link conditions to overall health status. This will improve health outcomes and improve patient healthcare compliance.
  - **Example:** Patient is morbidly obese with BMI >40. The patient has hypertension and diabetes. The weight does affect their other conditions. Discussing treatment to reduce weight will help improve their hypertension and diabetes. An overall treatment plan will improve all areas of health.
- Document in a non-judgmental way to better support management of care.
- Documenting accurate health status of patient will support continuity of care.

If It Isn't Documented It Didn't Happen

- **"If you didn't document it, it didn't happen."** This statement is often used in medical training as a method to strive for better documentation. This also helps to guard against malpractice suits.
- **"If you didn't document it, you're not getting paid."** This statement should be used more to support accurate reimbursement and patient management of care.
- Items to document during a patient encounter:
  - Plan of Service
  - What services are needed
  - Changes in the plan
  - Past & present treatment of physical and psychological conditions
  - Progress Notes
  - Health Information
  - Illnesses
  - Doctor's Orders
  - Medication
  - Unusual Incidents

Documentation Supports Coding & Billing

- **Fee for Service (FFS):** Although history and physical exam are no longer required to level the visit, they are still important components in establishing medical necessity, supporting medical decision making (MDM), and providing high-quality care. Documenting these components helps maintain continuity of care and assists other providers working with the patient. The assessment and plan (A/P) needs to be documented. If the total time is ambiguous or missing, the visit may be unbillable. If you document both MDM and total time, you can level the visit based on whichever is more advantageous, but you still must present documentation. Documentation of an A/P is also important in establishing medical necessity and maintaining continuity of care.
- **Risk Adjustment Diagnosis Coding Capture:** Detailed documentation and accurate diagnosis coding are critical for proper risk adjustment capture. Capture of HCCs are done on an Annual basis. All chronic conditions need a budget to manage care. When HCCs are captured documentation needs to support the diagnosis that is captured. There are many times HCCs are updated on an encounter but documentation is missing. This will affect the Risk Adjustment Factor that is created to manage patient care. Providing an update on a chronic condition will support diagnosis capture.
  - **Example:** Patient is being seen for Diabetes, A-Fib and CKD. The patient has started a insulin pump to better manage their blood sugar, A-Fib is stable and the patient follows up with Cardiology, CKD is improving as patient is now on a low-salt diet.

Overview of E/M Updates - FFS

- Updates to E/M were effective on January 1, 2021
- First updates in 24 years
- History and Exam are no longer key components of visit.
- The level of care will be driven by medical decision-making (MDM) **OR** by time.
- Time will include both face-to-face time and non-face-to-face time on the date of the visit.
  - Pre-Visit Review
  - Visit Encounter
  - Post-Visit Planning
- There is new MDM Table to calculate complexity in MDM
- The 99201 level of care has been deleted.
- 99211 will stay the same – Nurse Visit/Low Level Established Patient

Medical Decision Making (MDM) Supported by Documentation

- **Using Medical Decision Making (MDM)**
  - the number and complexity of problem(s) that are addressed during the encounter
  - the amount and/or complexity of data to be reviewed and analyzed, and
  - the risk of complications, morbidity, and/or mortality of patient management decisions made at the visit associated with the patient's problem(s), the diagnostic procedure(s), and treatment(s).
- **The history and exam are focused on the reason for the visit. They are not key components supporting leveling.**

Risk Adjustment Coding Overview

- A patient's risk score is captured accurately by coding to their disease and conditions to the highest specificity. HCCs are diseases and conditions that are organized into body systems or similar disease processes. The top HCC categories include:
  - Major depressive and bipolar disorders
  - Asthma and pulmonary disease
  - Diabetes
  - Specified heart arrhythmias
  - Congestive Heart Failure
  - Breast and prostate cancer
  - Rheumatoid arthritis
  - Colorectal, breast, kidney

Risk Adjustment Coding Overview

- NEPHO has some very specific coding and documentation practices in place to help support provider HCC performance. The following examples provide guidance to practices that are working to improve risk adjustment coding capture:
  - **Document and code all chronic conditions discussed and documented during a patient encounter:** Chronic and/or permanent diagnoses should be documented as often as they are assessed or treated.
  - **Clarify whether a diagnosis is "current" or "history of":** Anything that is listed as "repaired" or "resolved" should not be coded as current. Providers should be made aware of Z codes that are appropriate for these scenarios.
    - **Example:** Neoplasms that are current code to ICD-10 codes in Chapter 2: Neoplasms
      - Malignant neoplasm of prostate: C61
      - Malignant neoplasm of breast: C50
    - **Example:** Neoplasms that are no longer present should be coded to Chapter 21: Factors Influencing Health Status and Contact with Health Services
      - History of prostate cancer: Z85.46
      - History of breast cancer: Z85.3
  - **Update the patient's problem list regularly:** Make sure all problems listed as active are appropriate and haven't been brought forward (copied and pasted) in error.

Importance of Diagnosis Capture

- **Providers should document conditions they monitor and treat:** Diagnosis codes are not limited to what brought the patient to the office today. Any condition the provider monitors, evaluates, assesses, or treats should be included in the documentation.
- **Avoid using generic or unspecified codes:** Code to the highest level of specificity. Use of generic or unspecified codes does not fully support medical necessity and the management of care for the patient. Payers need to have an accurate picture of the patient's health status.
  - **Example:** Congestive heart failure should be coded by type and acuity. The term congestive heart failure is considered nonspecific, outdated, and inadequate to fully describe the condition. Documentation should be present in the record of systolic and/or diastolic failure or dysfunction and acuity.
    - Chronic diastolic (congestive) heart failure: I50.32
- **It is important to link manifestations and complications.** Providers need to make the link between a manifestation and complication. Some terms that can be used to link conditions are "because of," "related to," "due to," or "associated with."

Diagnosis Capture Supports Accurate Health Status

Select not only the diagnosis codes that describe why the patient was seen but also codes for any chronic conditions that affected treatment choices.

Examples:

- A patient with diabetes presents with severe poison ivy. The physician discusses the diabetes with the patient in deciding whether to use prednisone and documents it in the assessment. The physician should report poison ivy first and diabetes second.
- A patient followed by nephrology for chronic kidney disease (CKD) is seen by his family physician for hypertension, which is not well controlled. The physician considers and documents the CKD when selecting hypertension treatment, and should report hypertension first and CKD second.
- A patient with multiple chronic diseases presents for an annual exam. The physician reviews and documents the status of chronic diseases treated within the practice and by other providers.

If a patient has a serious chronic condition with a manifestation or complication that has its own code, use that code rather than an unspecified code.

Example:

- Code “Type 2 diabetes with retinopathy” instead of “Type 2 diabetes, uncomplicated” or “Varicose veins with inflammation or ulcer” rather than “Varicose veins, unspecified.”

Documentation Example Encounter 1: Morbid Obesity

- A patient has their yearly annual visit. Patient has always been in good health, but blood work shows some increases in certain areas (Cholesterol) . Patients weight & BMI have also increased putting the patients BMI at 40 that was at 32.
- Since the patients BMI is > 39 it would be coded as morbid obesity and would be added to the patient problem list as morbid obesity. (E66.01 Z68.41).
- When discussing the weight gain it is important to do it in a non-judgmental & non-stigmatizing way. The provider can ask the patient if there have been changes at home or with work. Do they continue to exercise on a regular basis.
- **Provider**: "You have gained weight this past year and I will need to document to ensure we monitor on an annual basis. I would like to review anything that could have caused the weight gain this year as if there is nothing different, I will want to order lab work to check your thyroid"
- **Patient**: "I did lose my job in the beginning of the year. I had to cancel my gym membership. I did just start a new job and will be re-joining the gym and working on losing weight."

Documentation Example
Encounter 2: Substance Abuse & Dependence

- A patient with a substance dependence is seen for their 3 month follow up. The patient is newly sober and is in a vulnerable state. They are working on their sobriety daily. The provider should encourage the patient to continue working their program and provide potential support opportunities to help support their sobriety such as: Private counseling, group therapy, yoga, meditation, and AA program.
- **Provider**: "I know you have been working on your sobriety for the last few months. How have you been doing in this new journey? Do you feel supported on this new journey? I would like to discuss additional support options that could help ensure your success with sobriety."
- **Patient**: "This has been a tough few months and I do feel vulnerable and scared of failing. I don't want to let my family and friends down and I feel like that is adding pressure."
- **Provider**: "I have a counselor I can refer you to who does specialize with clients in sobriety. They work with newly sober to long-term sober clients. I really think this will help you build a solid base to continue down the path you are on. I want you to know I am here to help support this wonderful step to better your physical and mental health. I want to make sure you are feeling well otherwise and there are no other health issues we should discuss."

Documentation Example
Encounter 3: Depression & Anxiety

- Patient being seen for routine follow-up Patient complains of decreased interest in things she used to enjoy. She is also experiencing decreased energy, concentration, and poor appetite. In addition she is having some family issues with son. PHQ 9 was filled out with a score of 5.
- It is important to let the patient know they are not alone in this and there are many ways to treat depression and anxiety that include counseling, medication and exercise/yoga.
- **Provider:** ”Together we can start a plan to address your depression & anxiety. I would like to refer you to counseling. It would be great to add yoga or meditation to your daily routine. I will start you on Zoloft to help interim and we will follow-up in 1 month to see how you are adjusting to medication and how you like your counselor. I will check in a few weeks out to see how you are managing. I understand this is difficult but there are treatment plans and we work together to make a plan best suited for you and your life. At this point I am not going to order tests as we will first focus on seeing if medication will help ”
- **Patient**: “Thank you for discussing as I have been scared and did not know where to turn. I have never taken medication to help with mood so I am a bit nervous.”
- **Provider:** “I understand and there are many times depression or mood can be affected seasonally. This will help see if this is what is needed to get you back on track. We will take a first step.”

Documentation Example
Encounter 4: Social Determinants of Health (SDOH)

- Patient is seen for Annual visit. The Patient's A1c and Hypertension have increased significantly. It has also been noted that the patient has missed some follow up appointments and has not requested refills on his medications to manage his health conditions. This is not typical behavior for this patient.
- **Provider:** "How have you been feeling? I've noticed you have missed a few follow up appointments with me, and I see your labs have increased. Are you currently taking your medications to help manage your Diabetes and Hypertension?"
- **Patient:** "I apologize for missing my last few appointments, I lost my job 6 months ago and I have not been able to afford some of my medications. I am afraid to get bills from doctor visits that I just can't afford right now."
- **Provider:** "I am very sorry to hear about you losing your job. As your Doctor I want to help you manage your health and chronic conditions. There are resources available to you that could help with the cost of medications. I am going to refer you to the community social worker that will be able to help guide you to potential services to better support your current living situation. I would like you to check in with me through the online portal to stay connected through this situation. We will discuss a plan to ensure you can stay on track with your plan of care.
- Discuss with your patient Social Determinants of Health (SDOH) and available community-based resources.
  - SDOH status of a patient can change. For example, opportunities for good health can be constrained after a job loss(Z56.0 Unemployment, unspecified).
  - Show sensitivity to your patient's feelings about disclosing his or her financial status. Discuss with your patients their SDOH and available community-based resources.
  - Drug discount cards can be helpful to patients as it can help to pay for partial prescription costs.

Resources

- Shawn.m.bromley@lahey.org
- Jessica.m.bryan@lahey.org
- https://www.manatt.com/insights/newsletters/covid-19-update/executive-summary-tracking-telehealth-changes-stat
- https://www.amazon.com/Adjustment-Documentation-Coding-Sheri-Bernard/dp/1622027337
- https://www.google.com/search?q=sdoh+meaning&rlz=1C1GCEB_enUS873US875&oq=sdoh&aqs=chrome.3.69i57j0i512j69i59j0i512l7.7053j0j7&sourceid=chrome&ie=UTF-8
- https://www.verywellhealth.com/medical-necessity-1738748
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