Risk Adjustment Documentation & Coding

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CHAPTER 2

Common Administrative Errors and Processes

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Medicare Rules

- The date of service must be documented.
- The encounter must be signed by the provider of services.
- The provider of services must be of a specialty type that is acceptable for risk adjustment.
- The documentation must be legible and acceptable.
- The patient must be for an enrollee in the program during the date of service.

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The Medical Record

- Coders must abstract from the medical record the diagnoses pertinent to today's encounter.
- The record must be authenticated by the treating provider and the date of service identified.
- **What are some of the elements seen in a typical medical record?**

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Patient Name and Demographics

- Medicare identifies patients by:
  - The name linked to the patient's Medicare enrollment. This name must be verbatim.
  - The patient's date of birth (DOB).
- Coders must verify the integrity of the patient identity.
- **What should a coder do if the record contains medical information for Robert Smith and Jason Smith?**

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Date of Service

- Date of service (DOS) is the date or the range of dates during which the patient received the described care. DOS is usually a face-to-face visit but may also be a telemedicine visit.
- **Why is the DOS crucial to a risk-adjustment claim?**

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CMS Signature Requirements

TABLE 2.1 Verifying Potential Errors and Taking Correction Actions: Signature Requirement Checklist

		SIGNATURE REQUIREMENT MET	CONTACT BILLING PROVIDER AND ASK A NON-STANDARDIZED FOLLOW-UP QUESTION
1	Legible full signature	X	
2	Legible first initial and last name	X	
3	Illegible signature over a typed or printed name **Example:** John Whigg, MD	X	
4	Illegible signature where the letterhead, addressograph, or other information on the page indicates the identity of the signatory **Example:** An illegible signature appears on a prescription. The letterhead of the prescription lists (3) physicians' names. One of the names is circled.	X	
5	Illegible signature **not** over a typed/printed name and **not** on letterhead, but the submitted documentation **is accompanied** by: a signature log, or an attestation statement	X	

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6	Illegible signature **not** over a typed/printed name, **not** on letterhead, and the documentation is **unaccompanied** by: a signature log, or an attestation statement **Example:**		X
7	Initials over a typed or printed name	X	
8	Initials **not** over a typed/printed name but **accompanied** by: a signature log, or an attestation statement	X	
9	Initials **not** over a typed/printed name **unaccompanied** by: a signature log, or an attestation statement		X
10	Unsigned typed note with provider's typed name **Example:** John Whigg, MD		X
11	Unsigned typed note without providers typed/printed name		X
12	Unsigned handwritten note, the only entry on the page		X
13	Unsigned handwritten note where other entries on the same page in the same handwriting are signed	X	
14	"Signature on file"		X

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CMS Signature Requirements *(continued)*

- **Electronic signatures**
  - **What are some of the accepted language formats for electronic signatures authenticating medical charts?**
  - **What are some that are not accepted?**
  - **What is the problem with the following example?**
    - **Example: Encounter Sign-Off**
      Encounter performed and documented by Jason Argo, PA
      Encounter reviewed and signed by Mildred Monson, MD, on 12/27/17 at 2 PM, encounter signed off by Mildred Monson, MD, on 12/27/17 at 2 PM

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Attestations

- Formal statement asserting that a specific medical record, while not authenticated sufficiently by the physician at the time of care, is authentic. An attestation must be signed by the author of the original record.
- Attestations are valuable if the physician has not authenticated a record and the record is being audited.

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Inpatient Records

- There are very few differences in inpatient and outpatient coding, except “rule-out” diagnoses appearing in a discharge summary may be coded as if they were proven.
- A properly authenticated discharge summary is key to coding inpatient records for risk adjustment.
  - Without this, the entire chart must be coded as if each encounter were separate, rather than as a hospitalization for a range of dates.

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EXAMPLE

COMPLIANT DISCHARGE SUMMARY (SIGNED BY PHYSICIAN A)	NONCOMPLIANT DISCHARGE SUMMARY (CODED FOR ENCOUNTERS FOR HOSPITALIST, ENDOCRINOLOGIST, LICENSED CLINICAL SOCIAL WORKER, AND VASCULAR CONSULTANT)		
DOS Jan 1, 2018 through Jan 3, 2018	DOS Jan 1, 2018	DOS Jan 2, 2018	DOS Jan 3, 2018
Diagnoses: E11.59, I10, F32.9, I82.409	Physician A: E11.59, I10, F32.9, I82.409	Physician A: E11.59, I10, F32.9, I82.409	Physician A: E11.59, I10, F32.9, I82.409
	Physician B: E11.59, I10, I82.409	Physician B: E11.59, I10, I82.409	Physician B: E11.59, I10, I82.409
	Physician C: F32.9	Physician C: F32.9	Physician C: F32.9
	Physician D: E11.59, I10, F32.9, I82.409	Physician D: E11.59, I10, F32.9, I82.409	Physician D: E11.59, I10, F32.9, I82.409

Note that this example is much simpler than most inpatient encounters would be in the real world. The patient is diagnosed with diabetes with vascular complications; hypertension; depression; and an acute deep vein thrombosis. In this example, we see that the compliant discharge summary allowed the RA coder to abstract the entire hospitalization as one episode of care, ie, with four codes. With a noncompliant discharge summary, each individual note from each physician for each day must be abstracted separately, ie, with 36 codes.

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Acceptable Providers for Risk Adjustment

- Providers must be directing the evaluation or treatment of the patient.
- **Turn to page 36 to review the list of acceptable physician specialty types for risk adjustment.**
  - **What type of nurses are acceptable as “physician specialty types?”**
  - **Would a properly signed X-ray report from a radiologist stating the patient has pneumonia be acceptable to code pneumonia in risk adjustment?**
  - **Would it ever be likely that an acceptable physician type would not be an acceptable provider?**

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TABLE 2.3 Examples of Acceptable and Unacceptable Facilities

RAPS PROVIDER TYPE	COVERED FACILITIES	NON-COVERED FACILITIES*
Hospital Inpatient	Short-term (general and specialty) Hospitals Religious Non-Medical Healthcare Institutions (formerly Christian Science Sanatoria) Long-term Hospitals Rehabilitation Hospitals Children's Hospitals Psychiatric Hospitals Medical Assistance Facilities/Critical Access Hospitals	Skilled Nursing Facilities (SNFs) Hospital Inpatient Swing Bed Components Intermediate Care Facilities Respite Care Hospice

*These are examples of non-covered facilities and not a comprehensive list.

Source: Pub. 100-16 Medicare Managed Care, Transmittal 116.

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Document Sources

- **Unacceptable document sources:**
  - Anything signed by an unacceptable source (eg, nurses' notes in an inpatient chart; laboratory report)
  - MS-DRG summary in an inpatient chart (administrative, not treatment)
  - Patient-transfer orders in an inpatient chart (administrative, not treatment)
  - Ambulance notes
  - Superbills
- **Exceptions**
  - When guidelines allow documentation from unacceptable providers
  - When the radiologist's report provides more granularity to the treating physician diagnosis, while not contradicting it (eg, adding more specificity to a fracture diagnosis)

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Problem Lists and Medication Lists

- Usually carried forward from a previous encounter documented in the electronic health record (EHR)
  - Difficult to authenticate as part of the current encounter
  - May include resolved or worsening conditions
  - CMS doesn’t always accept the codes abstracted from problem/medication lists

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EHR-Specific Issues

- Signatures
- Cloning
  - Within a single patient’s record
  - Among patients
- Altering text
- Sharing access passwords

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Chart Components

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Chief Complaint (CC)

- The CC is a statement by the patient regarding the reason for today's encounter. For example:
  - I am sort of breath.
  - I need a flu shot.
  - My prescriptions have expired.
- **Is the CC subjective or objective?**
- **May this be coded?**

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History of Present Illness (HPI)

- The HPI is a chronological description of the development of the patient's present illness from the first sign and/or symptom or from previous encounters to the present.
  - Usually contains information pertinent to coding and may contain some diagnoses that are not listed in the final assessment/plan
- **Is the HPI subjective or objective?**

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Review of Systems (ROS)

- An ROS is an inventory of body systems obtained through a series of questions to the patient, often in a sheet the patient is asked to fill out before the encounter.
- Not usually a good source of abstraction, but may list signs and symptoms that support diagnoses from the physician.
- **Is the ROS subjective or objective?**

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Past, Family, and/or Social History (PFSH)

- The PFSH is the patient's past illnesses and surgeries; the patient's recollection of the family's hereditary or other diseases; and a history of contributing factors (eg, the patient's marital status, smoking history, and drug or alcohol use).
- **Is the PFSH subjective or objective?**

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Physical Examination (PE)

- The PE is a visual and tactile examination of the patient by a physician, which may focus on all or a subset of anatomical systems. The level of detail on the physical examination is at the discretion of the physician and is based on the symptoms or disorders for which the patient is being seen.
- **Is the physical examination subjective or objective?**

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Assessment/Plan (A/P)

- An A/P is a list of the diagnoses assigned to the patient, and the treatment or diagnostic testing being performed to monitor the patient's conditions.
  - Usually listed at the end of the encounter.
  - The assessment may not be integrated with the plan, and the coder may need to infer which test being ordered is for which diagnosis.

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TABLE 2.7 Sample SOAP Note

Michael Barbados, DOB 9/23/1951	Morris Kointy MD office visit 1/27/2018
SUBJECTIVE: A brief narrative of the patient's chief complaint, including the history and symptoms associated with the complaint	Sudden onset of R shoulder pain following slip and fall on ice last week. Patient has had mild, chronic R shoulder pain for 2 years with a diagnosis of chronic rotator cuff injury. Sleep following the fall has been difficult due to exacerbation of shoulder paint when lying down.
OBJECTIVE: Physician examination and testing to determine the patient's condition	Before this encounter, patient underwent shoulder MR without contrast. MRI revealed 1. 0.5 x 0.7 cm high-grade partial thickness bursal sided rotator-cuff tear of the distal supraspinatus tendon. PE reveals limited ROM and tenderness at the acromion, AC joint, clavicle, bicipital grove, scapular spine, humeral head, supraspinatus tendon, and over the coracoid process.
ASSESSMENT: The physician's determination of the diagnosis(es)	Acute on chronic rotator-cuff tear
PLAN: The treatment that will be undertaken to correct the patient's problem	Patient has agreed to begin ibuprophen therapy and today received a cortisone injection to the bursa in the R shoulder. This injection may reduce inflammation and discomfort. The possibility of the need for surgery in the future was discussed, but for the short-term, the patient wants to see how his shoulder responds to NSAIDs and cortisone injections.

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Behavioral Charts

Axis	Description	Example
1	Acute clinical disorder Other comorbidities that may require attention	Major depressive episode, recurrent, severe Alcohol dependence
2	Personality disorder Intellectual disability	Avoidant personality disorder
3	General medical conditions that may influence behavior	Alcoholic cirrhosis, hypothyroidism
4	Psychosocial /environmental	Smoker; lives alone
5	WHO Disability Assessment Schedule	(not performed)

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Tips for Risk-Adjustment Coders

- Verify the patient by checking the name and DOB against the file's demographics.
- Go to the inpatient discharge summary and review the chart for a proper signature, then skim the entire file for additional diagnoses.
- For outpatient charts, start with the assessment/plan and then start again at the beginning.
- Look for diagnoses in the physical examination and the history of present illness, not just in the assessment/plan.
- Always code to the highest level of specificity and follow coding rules.

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