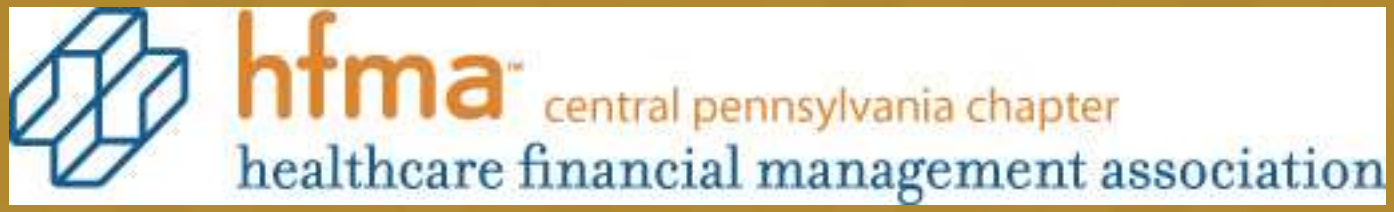


Electronic Health Record and Audit Risk: E&M Documentation in Turmoil

March 26, 2018

SunStone Consulting

OBJECTIVES

Participants will demonstrate an understanding of:

- Evolution of Electronic Health Records

- Risks of Electronic Health Records
  - Implications for Physician Practices
  - Ways to Mitigate the Risks

- E&M Services
  - Need for Change
  - Physician Perspective
  - CMS Proposed Changes
  - Impact of the EMR on E&M Services
  - Auditing Challenges
  - Working with Physicians

A BRIEF HISTORY OF THE ELECTRONIC HEALTH RECORD

Electronic Medical Record vs Electronic Health Record

EMR – Digital version of the paper record.

EHR – Represents the ability to easily share medical information among stakeholders and to have a patient's information follow him or her through the various modalities of care.

Timeline: 1960's – 1970's

- Prior to the 1960's – Paper records.
- Mid 1960's to the 1970's – Development of the first Clinical Information Systems:
  - Early 1960's – Mayo Clinic in Rochester, Minnesota.
  - 1968 - Massachusetts General launched the computer stored ambulatory record.
  - 1970's - University of Utah collaborated with 3M to develop HELP – one of the first decision support systems.
  - 1970's - VA – Decentralized Hospital Computer Program.
  - 1971 - Lockheed – Eclypsis.
  - 1972 - Regenstrief Medical Record System.

Early Purpose of the EHR

- To eliminate the logistical problems of the paper records.
- To reduce the work of clinical book keeping required to manage patients.
- To make critical information in the medical record accessible.

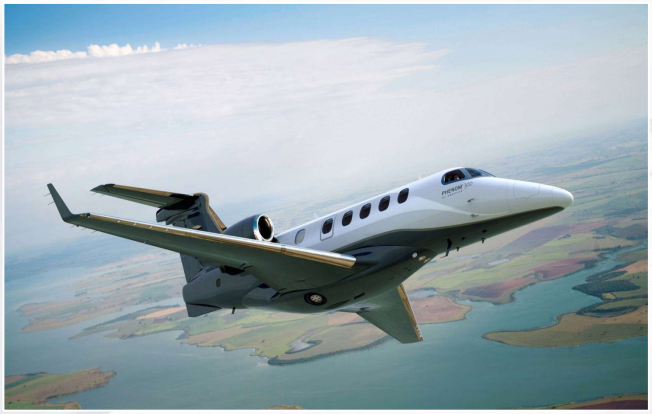
Timeline 1980's - Current

- Continuing Evolution of the EHR:
  - 1987 - Health Level 7.
  - 1991 - Institute of Medicine (IOM) sponsored studies that led the way to the concept of the electronic record we have today.
  - 2003 – IOM decided upon the terminology of electronic health record.
  - 2004 – 2009 Office of the National Coordinator for Health Information Technology (ONC).
  - 2011 – CMS creates the EHR incentive programs.

The Transformation

Goals unchanged, just enhanced…

Wow, this thing can fly, and I get paid too?



RISKS WITH ELECTRONIC HEALTH RECORDS

Downfalls of Rapid Development

- Lack of regulatory framework.
- Records developed from erroneous or incomplete design specification.
- Records are dependent on unreliable hardware or software platforms.

Downfalls of Rapid Development

- System errors or bugs.
- Works well within one organization, but fails with another;
  - Work product dependent on vendor team assigned to facility.
  - Aggressive timelines.

THE IMPACT FOR PHYSICIANS

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The EHR Impact on Physicians' Daily Routine

- Clinician daily routines change, but introduce potential failure modes:
  - Poor system usability and improper system use.
  - Inappropriate documentation capture.
  - Errors related to clinical decision support.
  - Copy/Paste.
  - Templates.

The Consequences for Physician Practices

Office of the Inspector General (OIG): Not all Recommended Fraud Safeguards Have Been Implemented in Hospital EHR Technology. December 2013 -

"Copy-pasting, also known as cloning, allows users to select information from one source and replicate it in another location. When doctors, nurses, or other clinicians copy-paste information but fail to update it or ensure accuracy, inaccurate information may enter the patient's medical record and inappropriate charges may be billed to patients and third-party health care payers. Furthermore, inappropriate copy-pasting could facilitate attempts to inflate claims and duplicate or create fraudulent claims."

The Consequences for Physician Practices

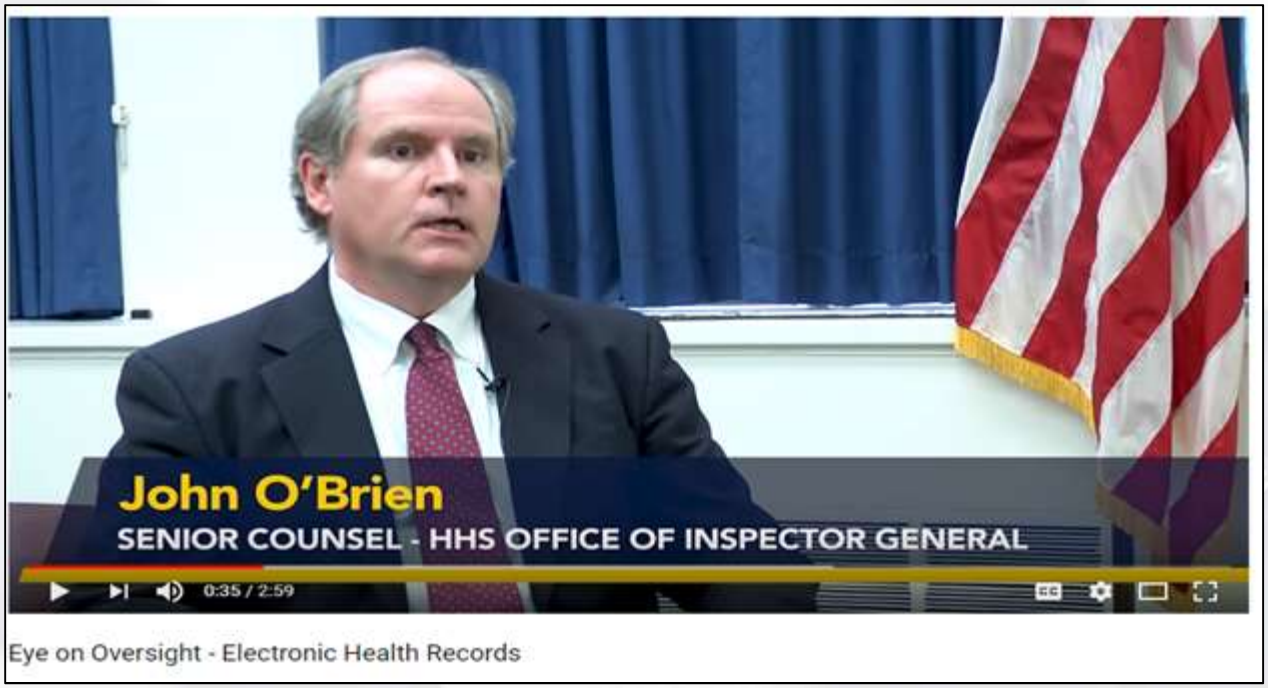
OIG June 2017: Medicare Paid Hundreds of Millions in Electronic Health Record Incentive Payments That Did Not Comply With Federal Requirements –

"We recommend that CMS review eligible professional incentive payments to determine which eligible professionals did not meet meaningful use measures for each applicable program year to attempt recovery of the $729.4 million in estimated inappropriate incentive payments."

Consequences for Vendors

Office of the Inspector General

- Electronic Health Record vendors have been put on notice.



Eye on Oversight - Electronic Health Records

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MITIGATING THE RISKS

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EHRs Are Here to Stay, So What Do We Do?

- Reduce EHR system design flaws.
- Improve system usability and proper use.
- Improve documentation capture processes.
- Minimize errors resulting from clinical decision support systems.
- Report adverse events.

E&M SERVICES:
TIME FOR CHANGE

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Problem Identified

"E/M codes do not accurately describe the services furnished to Medicare beneficiaries and do not accurately reflect the relative resources involved with furnishing those services."

– *Letter to CMS from the American Academy of Family Physicians; August 26, 2015.*

E&M Codes - History

- 1992: AMA introduces E&M codes; defined in terms of three key components (history, examination, and medical decision-making).
- 1995: CMS releases the 1995 E&M Guidelines.
- 1997: As result of significant criticism of the 1995 E&M Guidelines, CMS publishes the 1997 E&M Guidelines; with specialty specific physical exams.

Problems with E&M Codes #1

- E&M codes represent a complex system:
  - CPT descriptions with vague terms such as “expanded problem focused exam.”
  - 1995 Guidelines introduced slightly more specificity with “documentation guidelines.”
  - 1997 Guidelines with medical specialty exams.
  - Lack of standardization in determining complexity of medical decision making (MDM).
  - CPT definitions vague.
  - Most payers use the Marshfield Clinic Tool model with points awarded for medical decision making.

Problems with E&M Codes #2

- Relative lack of coding instruction;
  - Payers, providers and billing organizations develop their own interpretations.

Problems with E&M Codes #3

- Not flexible so as to account for medical specialty differences in focus, medical decision making and time.
  - Overemphasis on traditional histories and physicals.
  - Overlooking the importance of physician knowledge and expertise.

Problems with E&M Codes #4

- 20+ year old guidelines out of date and conflict with new models of team based care:
  - Increased use of ancillary staff and care coordinators whose documentation should be incorporated into the E&M coding structure.

Problems with E&M Codes #5

- Structure based on fee-for-service model;
  - Physician “rewarded” for doing more rather than focus on quality and medical necessity.
  - Valuation of E&M services has not evolved with increased scope and complexity of care.

PHYSICIAN PERSPECTIVE

American College of Physicians (ACP) Position Paper 2015

- E&M Guidelines “largely redefined cognitive services as not what was done, but rather what was documented.”
  - Definition of a good note no longer comes form clinical professors but from professional coders and corporate compliance staff.

- Guidelines turned care into a 2-step process; caring for the patient and “backfilling” a note to fit an arcane documentation format.

American College of Physicians (ACP) Position Paper 2015

"These guidelines created a complex system of rules that further specified format requirements. This has created an imbalance of values, with coding and compliance trumping clarity and conciseness, as well as a harshly negative "gotcha" mentality that saps the professionalism out of physicians."

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The E&M Challenge

"Our challenge is to find some way to translate our cognitive labor into the abstruse language of the E&M guidelines without wasting time on over documentation or getting distracted from our real job of taking care of patients." – Peter Jensen, MD, CPC of E&M University

CMS AND E&M SERVICES: FINALLY TAKING NOTE

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CMS Paying Attention

- 2018 Physician Fee Schedule Final Rule. CMS acknowledges:
  - E&M Guidelines *"burdensome".*
  - Outdated *"especially true for the requirements for the history and physical exam."*
  - E&M Guidelines *"have not been updated to account for changes in technology especially electronic health record (EHR) use."*

CMS Paying Attention

- CMS believes *"reform of E&M documentation guidelines would require a multi-year, collaborative effort among stakeholders."*
- "*We stated that we believed MDM and time are the most significant factors in distinguishing visit levels…"*
- *"It may be possible to eliminate the focus on details of history and physical exam and allow MDM and/or time to serve as the key determinant of E&M visit level."*

E&M SERVICES:
IMPACT OF THE EMR

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Impact of the Electronic Medical Record

- E&M “creep”
- “Over-documentation”
- Cloning of documentation
- Inaccuracy of documentation
- Screen clutter for physicians
- Loss of physician cognitive work

Office of Inspector General May 2012 Report – "E&M Creep"

- Analyzed coding trends of E&M services from 2001 to 2010:
  - Physicians increased their billing of higher level E&M codes across all types of E&M services; "E&M creep."
- First in a series of future evaluations of E&M services:
  - Appropriateness of Medicare payments for E&M services.
  - Assess extent of documentation vulnerabilities in E&M services using electronic health record systems.

“E&M Creep” – E&M Code Generators

- EMR product automates the process of determining the E&M code based on the documentation. Proper software design should account for:
  - Medicare Administrative Contractor policies
  - 1995 and 1997 E&M Guidelines
  - Dictated portions of a progress note
  - Different levels of medical decision making

E&M Overdocumentation

- Use of EMR functionality of bringing forward previous information
  - History of the Present Illness – "HPI"
  - May be difficult for auditor to identify relevant HPI for a specific encounter.

- Past Medical, Family and Social History
  - Practitioners should note their review but typically do not.

  - Information brought forward that is no longer relevant **or even accurate.**

Example - HPI Brought Forward

History of Present Illness:

Jane Doe is seen today for reassessment of her adenocarcinoma of the left upper lung status post resection followed by 4 cycles of cisplatin and Alimta adjuvant chemotherapy which ended at the end of August 2009. Since her last visit with us in July she has had progressive vocal cord issues with hoarseness. She has increased shortness of breath with exertion and increased throat pain. She was evaluated by gastroenterology who felt she may have reflux and ENT who felt there was more of a possible nervous dysfunction since the cords didn't close properly. She is going for speech therapy. She still has some slight neuropathy in her feet. She has no hearing problems but fatigue is persistent.

6/27/14: Since last seen got treated for GERD and hoarseness symptoms have resolved. No new problems. Sees Dr. Trent for pulm next appt in Sept 2014.

10/13/15: Patient did have an increasing shortness of breath and wheezing. CT scan showed hilar lesion 1.7 x 4.3 cm. with multiple bone lesions. There was a marked delay in getting her scan as her insurance company initially denied PET scan and approved CAT scan. The facility do not compared to previous xrays and did a bone density rather than a bone scan. She is due for a bone scan tomorrow at our facility but because of the COPD exacerbation have given Dr. Verna a call to see if we can direct admission for medical stabilization.

10/21/15: Patient was hospitalized, had scan performed which showed bone lesions, biopsy was performed on the bone lesion was positive for carcinoma. Unfortunately, the staining machinery broken down at the hospital and the material at the send out for immunostains for identification. Patient is extremely upset that we do not have a final diagnosis with her today. I did inform her that this is most likely recurrent adenocarcinoma she's had in the past. Dr. Barnes and formulated he will call me as soon as the final pathology is back. I will start authorization for her chemotherapy in anticipation of adenocarcinoma and will change it if it is a different tumor type.

10/29/15: Awaiting EGFR, ALK, and ROS results. Had second opinion with Dr. Sullivan, agree with regimen. Having increasing hip discomfort, discussed having rad onc input. Will hold off avastin for cycle #1. Discussed with Dr. Dragun.

11/19/15: Patient is here for cycle #2 of her chemotherapy. This tolerating it quite well with just some queasiness today 3,4, and 5. She is undergoing radiation but will be done in the next 10 days. Her genomic testing came back with negative alk gene rearrangement, inconclusive ROS.

Example - Relevancy of History Brought Forward

Active Problems:

1. Abnormal liver enzymes (R74.8)
2. Acid indigestion (K30)
3. Acquired deviated nasal septum (J34.2)
4. Aortic regurgitation (I35.1)
5. Back pain (M54.9)
6. Chest pain (R07.9)
7. Cystocele, midline (N81.11)
8. Depression (F32.9)
9. Dermatitis (L30.9)
10. Elevated liver function tests (R79.89)
11. Fatty liver (K76.0)
12. Headache (R51)
13. Hearing loss (H91.90)
14. Hypercholesterolemia (E78.00)
15. Hypertension (I10)
16. Hypertrophy of nasal turbinates (J34.3)
17. Hypothyroidism (E03.9)
18. Impaired fasting glucose (R73.01)
19. Low back pain (M54.5)
20. Microscopic hematuria (R31.29)
21. Mixed conductive and sensorineural hearing loss (H90.8)
22. Nasal congestion (R09.81)
23. Osteopenia (M85.80)
24. Pain in foot (M79.673)
25. Pain, wrist joint (M25.539)
26. Peripheral neuropathy (G62.9)
27. Pessary maintenance (Z46.89)
28. Solitary thyroid nodule (E04.1)
29. Spasm of thoracic back muscle (M62.830)
30. Supraclavicular fossa fullness (R22.2)
31. Trigger finger of left hand (M65.342)
32. Upper back pain (M54.9)
33. Urinary symptom or sign (R39.9)
34. Vaginitis (N76.0)
35. Vitamin D deficiency (E55.9)
36. Well woman exam with routine gynecological exam (Z01.419)

E&M Overdocumentation

- Over-reliance on use of auto populated templates; Review of Systems (ROS) and Physical Exam.
  - A complete ROS is auto populated with “negative” for all 14 body systems.
  - Multisystem or specialty exam is auto-populated with normal findings.

E&M Overdocumentation

- Practitioner should edit based on information gotten from patient and/or exam findings. Failure to do so results in:
  - Questions about what work performed.
  - Incongruity of information.
  - Overdocumentation relative to the patient's presenting problem(s).

Example - ROS – Auto-Populated

Review of Systems:
Constitutional: Negative for fever, chills and malaise/fatigue.
HENT: Negative for sore throat, swelling, nasal dripping.
Respiratory: Negative for cough, sputum production, shortness of breath and wheezing.
Cardiovascular: Negative for chest pain, palpitations
Gastrointestinal: Negative for nausea, vomiting, abdominal pain
Genitourinary: Negative for dysuria, urgency, frequency.
Musculoskeletal: Negative for myalgias and falls.
Skin: Negative for rash, neurocutaneous stigmata.
Neurological: Negative for focal weakness and headaches.

Example - Incongruity of Information

Review of Systems
Constitutional: Negative for fever, chills and malaise/fatigue.
HENT: Negative for sore throat, swelling, nasal dripping.
Respiratory: Negative for cough, sputum production, shortness of breath and wheezing.
Cardiovascular: Negative for chest pain, palpitations
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Genitourinary: Negative for dysuria, urgency, frequency.
Musculoskeletal: Negative for myalgias and falls.
Skin: Negative for rash.
Neurological: Negative for focal weakness and headaches.

Imp/Plan:
1. PD: Continue home dose sinemet for now
2. Constipation: Colace, dulcolax
3. Nausea, anorexia: IVF, zofran prn. Repeat labs.
4. Debility: secondary to the above: Therapies to see.
5. DM: Hold orals. WBSS
6. HTN: Home meds. Hold for hypotension. Check orthostatics.
7. VTE prophylaxis: lovenox
8. Dispo: May need inpatient rehab

Example - Multisystem Exam – Auto-Populated

Physical Exam:
Constitutional: He is oriented to person, place, and time. He appears well-developed and well-nourished.
HENT:
Head: Normocephalic and atraumatic.
Mouth/Throat: Oropharynx is clear and moist.
Eyes: Conjunctivae and EOM are normal. Pupils are equal, round, and reactive to light.
Neck: Normal range of motion. Neck supple.
Cardiovascular: Normal rate, regular rhythm and normal heart sounds.
Pulmonary/Chest: Effort normal and breath sounds normal.
Abdominal: Bowel sounds are normal. There is no tenderness. There is no rebound and no guarding.
Musculoskeletal: Normal range of motion. He exhibits no edema or deformity.
Neurological: He is alert and oriented to person, place, and time. No cranial nerve deficit.
Skin: Skin is warm and dry.
Psychiatric: He has a normal mood and affect. His behavior is normal. Judgment and thought content normal.

Questionable Overdocumentation

Urgent Care: 2 yr. old with cold symptoms. Diagnosis was acute URI; no meds ordered.

Physical Exam:

General/Constitutional: Patient appears well nourished, well developed and in no apparent distress.
Head/Face: Normocephalic, atraumatic, symmetrical.
Eyes: No exophthalmos, lid swelling or conjunctival injection. Pupillary reaction wnl. EOMS intact.
Ears: Hearing grossly normal, canals clear, tympanic membranes intact.
Nose/Throat: No visible nasal deformity. Mucous membranes in tact. Tongue and throat wnl. No mucosal lesions.
Neck/Thyroid: Supple without meningismus, adenopathy or palpable thyroid enlargement.
Respiratory: Symmetrical and clear to auscultation without wheezes, rhonchi, or crackles.
Cardiovascular: Normal S1 and S2. No audible murmurs, rubs or gallops.
Integumentary: No impressive skin lesions visible, nails are normal appearing, hair distribution is wnl.
Spine: No remarkable kyphosis or scoliosis, no significant tenderness, ROM is globally normal.
Musculoskeletal: Musculature globally wnl. No impressive skeletal tenderness or joint deformity.
Extremities: Extremities globally normal in appearance. No evident edema or cyanosis.
Neurological: Alert and oriented times 3, cranial nerves II, III, IV, and VI grossly intact, intellect grossly normal, no focal deficits.
Psychiatric: No overt signs of anxiety or depression.

Orders and Procedures Performed at NextCare:

Discharge Disposition: Stable
Diagnosis: Acute URI Nos

Cloning

The OIG in its 2013 Work Plan notes:

"We will also review multiple E/M services for the same providers and beneficiaries to identify electronic health records (EHR) documentation practices associated with potentially improper payments. Medicare contractors have noted an increased frequency of medical records with identical documentation across services. Medicare requires providers to select the code for the service on the basis of the content of the service and have documentation to support the level of service reported."

Cloning

First Coast Services Options, Inc. notes as follows:

"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 documentation will lead to denial of services for lack of medical necessity and recoupment of all overpayments made." - (Emphasis added by First Coast Services Options, Inc.)

Cloning Example

Pain management physician statement of medical necessity found in multiple records for multiple patients with differing diagnoses and different procedures:

> This procedure is medically necessary and indicated based on this patient's medical history, physical examination, diagnostic studies, clinical presentation and symptoms. The patient has failed to respond to home exercise program, activity modification, including a walking program, NSAID's x 6 weeks, heat and ice therapy, acetaminophen, and controlled physical therapy programs.

Cloning Example

Examination found for a physician's established patient visits for multiple visits over a four year period:

Exam:

General appearance: well developed. no acute distress.
Head: holds erect and midline, facial features symmetric.
ENMT: normal.
Neck: ***neck***: supple, no masses, trachea midline.
Respiratory: ***auscultation***: no rales, rhonchi, or wheezes.
Cardiovascular: ***auscultation***: regular rate and rhythm.
Chest: normal.
GI: ***liver and spleen***: no enlargement or nodularity.
Abdomen: soft, nontender, bowel sounds normal, no masses.
Lymphatic: normal.
Skin: normal.
Psychiatric: ***mood and affect***: appropriate mood and affect.

Example - Screen Clutter

Service: NeurologyVital Signs-Last Charted:

VS	Value	Date/Time	24 H Range
Temp (degrees F)	97.7	08-19-2016 16:58	(97.3 - 97.7)
Temp (degrees C)	36.5	08-19-2016 16:58	(36.2 - 36.5)
Heart Rate (beats/min)	72	08-19-2016 16:58	(67 - 81)
Respiration (breaths/min)	18	08-19-2016 16:58	(16 - 18)
SpO2 (%)	96	08-19-2016 16:58	(95 - 97)
SpO2 Patient On	room air	08-19-2016 16:58	
BP Systolic/Diastolic	(91/64)	08-19-2016 16:58	(91 - 134/104 - 64)
Weight Daily (kg)	74.5	08-17-2016 19:55	

Active Medications 1. AmLODIPine 5 mg Oral Daily 2. Aspirin - Enteric 81 mg Oral Daily 3. Atorvastatin 80 mg Oral at bedtime 4. Brimonidine 0.2% Opth 1 Drop Both Eyes BID twice daily 5. Carbidopa-Levodopa 25-100 mg ODT 1 Tab Oral Q 24 hours 6. Carbidopa-Levodopa 50-200 mg CR 1 Tab Oral <User Schedule> 7. Carbidopa-Levodopa 50-200 mg CR 1 Tab Oral <User Schedule> 8. Carbidopa-Levodopa 50-200 mg CR 2 Tab Oral <User Schedule> 9. Carbidopa-Levodopa 50-200 mg CR 2 Tab Oral <User Schedule> 10. CLONazepam 0.25 mg Oral at bedtime 11. Docusate-Senna 1 Tab Oral at bedtime 12. Dorzolamide-Timolol 2%-0.5% Opth 1 Drop Both Eyes BID twice daily 13. Doxycycline Oral Tab/Cap 100 mg Oral BID twice daily 14. Enoxaparin 40 mg Subcutaneous Q 24 hours 15. Entacapone 50 mg Oral <User Schedule> 16. FluOXeTINE Oral 20 mg Oral Daily 17. Gabapentin Oral Cap/Tab 100 mg Oral Daily 18. Gabapentin Oral Cap/Tab 200 mg Oral at bedtime 19. Gemfibrozil 600 mg Oral Daily 20. Lanolin/Min Oil/Pet Opth Oint 1 application Ophthalmic at bedtime 21. Latanoprost Opth 1 Drop Both Eyes at bedtime 22. Niacin Immed Release Tab/Cap 500 mg Oral Daily 23. Omega-3 Acid Ethyl Esters 1 Gm Oral Daily 24. PanTOPrazole Oral 20 mg Oral Daily 25. QUEtiapine 25 mg Oral Daily 26. Tamsulosin 0.4 mg Oral Daily 27. TraMADol 50 mg Oral at bedtime 28. TraMADol 50 mg Oral at bedtime 29. Vitamin B12 Oral 1000 mcg Oral Daily 30. Vitamin C Oral 500 mg Oral Daily at 0700

Active PRN Medications 1. Acetaminophen Oral 650 mg Oral Q 4 hours PRN 2. Bisacodyl Rectal Supp 10 mg Rectal Daily PRN 3. Docusate-Senna 1 Tab Oral BID twice daily PRN 4. Miralax Pwd 17 Gm Oral BID twice daily PRN 5. Sodium Biphosph-Sodium Phosph Enema 118 ml Rectal Daily PRN

Active Antibiotics 1. Doxycycline Oral Tab/Cap 100 mg Oral BID twice daily

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Loss of Physician Cognitive Work

Subsequent inpatient hospital note, billed as high level 99233:

Plan
Assessment
TIA

STATUS MIGRAINE
Plan
SEE ORDERS

DC HOME TODAY
Orders

AUDITING CHALLENGE: OUR APPROACH

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Auditing Conundrum

- "Note bloat;" progress notes that are 10 or 12 pages long.
- Difficulty determining what information is relevant to a specific encounter.
- Authentication issues; determining who contributed to what part of the progress note.
- It's documented, but was it done?
  - Giving the practitioner the benefit of the doubt.

Medical Necessity

"Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported." - Medicare Claims Processing Manual, Chapter 12, § 30.6.1

E&M in the EMR – Our Approach

- If only the date of service and vital signs are different, we will consider the progress note cloned and recommend that the entire encounter should not be billed.

- When we identify practitioner over reliance on the use of templates, we will choose to assign more weight to the complexity of the medical decision making component of the E&M encounter.

E&M in the EMR – Our Approach

- If there is incongruity of information in the progress note, we credit the physician only with information that is congruent.

- Information that is a copy/paste and unchanged from a previous encounter; specifically the HPI and/or “Assessment/Plan” portion of the progress note:

  - We credit the practitioner only for those documented elements that have changed from the previous visit(s) and/or are ***unambiguously unique*** for that specific patient encounter.

E&M in the EMR – Our Approach

- Final determination regarding the billed service(s) based on clinical judgment; whether the documentation of the history, physical exam and/or physician medical decision making is congruent with the patient's presenting problems/symptoms and level of E&M CPT code selected.

- Looking for the outliers; records where there is ***unambiguous misuse*** of EMR functionalities.

WORKING WITH PHYSICIANS

Physician Education – What Works

- Best approach shown to be one to one “coaching;” with physicians; shadowing their documentation in real-time.
- Teach physicians what coders/auditors are looking for; i.e. why they need to state they reviewed labs rather than assuming presence of labs means they reviewed it.
- Detailed education regarding the E&M medical decision making “system;” they become much more clear about what they need to document and why.

Emphasizing Medical Decision Making

- Portion of the E&M encounter that captures the physician's cognitive work, yet physicians tend to under-value and under-document.

- The most complicated portion of the E&M encounter from a coding/auditing standpoint and thus the development of a point system to more objectively quantify physician work.

Medical Decision Making

The complexity of the medical decision making should drive the assignment of the E&M level; consider it the most important component of the E&M encounter.

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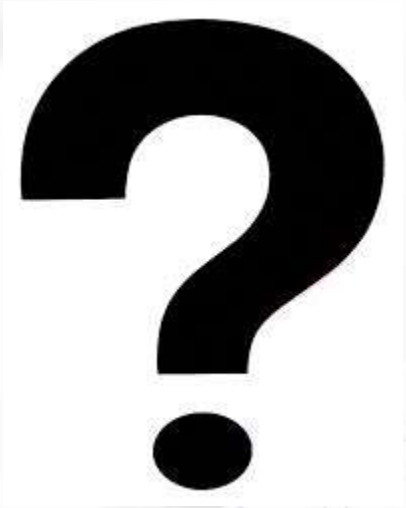
Questions



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THANK YOU

Presenters

Laura Ehrlich, RN, BSN, CCM, COC
Senior Clinical Specialist
lauraehrlich@sunstoneconsulting.com
(717) 968 - 5035

Georgia Rackley, MSN, RN, CPC, CLNC
Senior Clinical Specialist
georgiarackley@sunstoneconsulting.com
(717) 574 -1947

www.sunstoneconsulting.com

SunStone Consulting