MONTHLY TIPS AND TRICKS: AVOIDING PENALTIES

BEST PRACTICES FOR APPROPRIATE PROVIDER DOCUMENTATION

ALWAYS:

- Maintain accurate and complete medical records and documentation of the services you provide.
- Make certain that the services rendered are appropriate, **medically necessary** and are supported in your documentation.

"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." - CMS Internet Only Manual (IOM) Medicare Claims Processing Manual, Publication 100-04, Chapter 12, Section 30.6.1

Good documentation practices help other providers, who may rely on your records for an accurate clinical picture of your patient. It is vital to continuity of care.

AVOID:

- **Copying and pasting the documentation in the patient's EMR from a previous encounter to the current one.**

"Cloning" (copying portions of an existing record and adding it to another) is a potential source of inaccurate information entered into the patient's record and could lower the integrity of the documentation. This could result in inappropriate charges being billed to patients and payers, or worse – compromise quality of care.

REMINDER: an unsigned medical record has no legal validity. If a note is not signed, it does not support the service billed.

ACCURATE CODING AND BILLING

When you submit a claim for services performed for a Medicare or Medicaid beneficiary, you are filing a bill with the Federal Government certifying that the payment requested was earned and all billing requirements were met.

To maximize reimbursement and minimize denials:

- Document in full all services rendered
- Make a note of medical necessity when providing medical services
- Make sure that services are provided and documented by a properly supervised, qualified staff member
- Bill only for services performed by staff active and participating with Medicare/Medicaid
- Avoid billing separately for services already included in a global fee
- Make sure you have all documentation and the right CPT code to avoid unnecessary errors

Remember, duplicate billing may cause denial of a claim.

CAUTION • CAUTION • CAUTION • CAUTION

UPCODING: COMMON EXAMPLES

- Providing a follow-up office visit or follow-up inpatient consultation, but billing a higher level E&M code as if a comprehensive new patient office visit or an initial inpatient consultation was provided
- Misuse of Modifier 25. Modifier 25 allows additional payment for a separate E&M service rendered on the same day as a procedure. Upcoding occurs if a provider uses Modifier 25 to claim payment for an E&M service when the patient care rendered **was not significant, was not separately identifiable, and was not above and beyond the care usually associated with the procedure.**
- Using an unnecessarily high volume of documentation to justify a higher level of service than is supported by **medical necessity**

For more information, visit https://oig.hhs.gov/compliance/physician-education/roadmap_web_version.pdf