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Care documentation

Be specific about 'physically present,' 'immediately available' to avoid denials

Make sure your physicians provide detailed notes when they supervise residents at the hospital, as sloppy and scanty documentation can lead to contractor challenges — and worse.

It's no secret that attending physicians can be harried, and one of the more common ways for them to cut corners is in their teaching physician notes. "Doctors forget because they get so busy," says Lori-Lynne A. Webb, a coding consultant in Melba, Idaho. "So on the coder side, you have to be diligent about asking the doctor for the documentation."

*(see **Teaching physicians**, p. 6)*

Practice management

Use EHR prompts to boost treatment compliance, follow-up care, practice revenue

Set up point-of-care alerts within your electronic health record (EHR) to create a seamless reminder for physicians and office staff and gain an income advantage when you increase use and administration rates of available services.

Investing the relatively small amount of time to set up EHR prompts allows you to alert providers of services, such as vaccines, that are relevant to specific populations, or you can fine-tune the prompts to offer a treatment plan for particular conditions, such as diabetes.

*(see **EHR**, p. 7)*

Woodward, subject matter expert for DecisionHealth based in Gaithersburg, Md. Check with your private payers to make sure their contracts allow this as well.

But you can't "have the patients pay for them outright and not bill the insurance." That's a violation of your terms of service, says Pam Thompson, owner of Thompson & Associates, a practice management consultancy in Los Angeles. The patient may be responsible for a co-pay, but the supplier must bill Medicare.

Alternately, the provider can "shop around" for a different supplier as well as negotiate rates with the pessary supplier if he or she wishes to supply the pessary. As with other durable medical equipment or vaccines, the supplier may be incentivized to offer you a discount by the prospect of large or continuing orders *(PBN 12/8/14)*. "Some large vendors, such as Moore Medical, often offer a 20% discount on their invoices if the medical practice buys all their supplies from Moore," says Thompson.

One other thing, says Woodward: Tell your patient to be careful with the device. "Any puncture to the outer covering or other opening would result in a compromise to the sterile environment and a major infection risk," she says. — *Roy Edroso (redroso@decisionhealth.com)*

Teaching physicians

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Bad documentation can have serious consequences in these teaching-physician cases. "I've been involved in a number of cases" related to teaching physicians' notes, says Harry Nelson, a partner with the Nelson Hardiman law firm in Los Angeles. He sees "a widespread practice of documenting supervision that often consisted of nothing more than signing off on what the resident did independently."

It gets worse: "For example, in one case, a woman presented to the hospital with symptoms of chest pain and elevated levels of troponin, indicating a possible heart attack," says Nelson. "The resident evaluated her and sent her home on his own, while writing 'discussed and confirmed recommendation with attending.' In fact, there had been no such discussion; the resident knew that this attending cardiologist did not want to be bothered and in the past had told him to handle straightforward cases all by himself. The woman came back a few hours later with more severe symptoms of a heart attack and it was clear that sending her home had been a mistake."

Show you did the work

Even if it doesn't blow up like that, experts acknowledge that "reviewed discussed and agreed" notes won't do for E/M work. The teaching physician's documentation "should reflect the analysis of the patient's condition" at the level required to make the claim, Nelson says.

For example, teaching physicians should document involvement in as many elements as the claimed service requires — that is, two of three or three of three elements of history, exam and medical decision-making for established patients and all three for new ones. If the resident does two and the teaching physician actively

participates in only one, the claim may be questioned, says Kelly Berge, online chair at the Berkeley College School of Health Studies in Clifton, N.J.

Keep your terms straight

Key phrases document the presence of the teaching physician in notes and should be consistent, says Doris Branker, president of DB Healthcare Consulting & Education in Fort Lauderdale, Fla. For example:

- **Physically present** — The teaching physician is located in the same room — or in the partitioned or curtained area, if the room is subdivided to accommodate multiple patients — as the patient and/or performs a face-to-face service.
- **Immediately available —** The teaching physician is within a distance that allows him or her to return to the surgical suite immediately if needed.
- **Critical or key portion** — The part or parts of a service that the teaching physician determines is or are a critical or key portion(s).

In procedures, a good rule of thumb is that the doctor should attest that "I was physically present for the critical and key portions and immediately available for the whole procedure." When a procedure is five minutes or fewer, the physician must be physically present throughout and continuously or she can't report it, Branker adds.

You don't need to spell out what portions are "key and critical" because no good official measurement of the term exists. "It's still a fluffy gray cloud," says Webb.

One thing auditors are very clear on, though, is "immediately available," to which physicians often give a liberal interpretation. "Sometimes physicians claim they were immediately available, and it turns out they'd gone to lunch," Branker says. "Your hospital may require that the teaching physician be on call and available, say, within 30 minutes — but that's not the same as what the government requires. In anesthesia for obstetrics, patients can be in labor for hours. Doctors may say, 'they have my pager, I can be back in 15 minutes,' but that's not immediately available."

Should it come to an investigation, your physician's access trail may be tracked by his or her IP address if he attested remotely, which would blow any "immediately available" claim, Branker points out.

Beware unmodified macros

Teaching physicians need to beware of cloned or cloned-looking notes. The hospital electronic health records may populate fields in a way auditors find suspiciously generic. For example, a macro or template for an anesthesiologist might say, "present for all key and critical elements and immediately available to furnish services including, if applicable, Swan-Ganz, central line, etc." If the physician leaves it unedited, it could be problematic, Branker says.

"The auditor could question it because information within the record that is customized to the patient would not include this statement when the patient did not have those ancillary services performed," says Branker.

Watch your modifiers, time

While teaching physicians generally add the **GC** modifier (Service has been performed in part by a resident under the direction of a teaching physician) to claims for services they supervise, they may overlook the coding change they have to make when they do a procedure on the hospital floor by themselves — or with a non-resident colleague.

When an attending who's been doing teaching physician claims finds herself without a resident on the floor, needs assistance on a procedure, pulls an M.D. colleague in and then puts the claim in with two providers, they should remember that the GC no longer applies. An assistant-at-surgery modifier, such as **82** (Assistant at surgery when a qualified resident surgeon is not available to assist the primary surgeon), should be used, says Berge.

Also, be aware that certain types of procedures and work-sharing require tweaks to the claims. For example, with timed critical care E/M services, if the resident stabilizes the patient and the physician follows up, the physician can't claim his or her own time toward the critical care E/M. — *Roy Edroso (redroso@decisionhealth.com)*

Editor's note: *Doris Branker's comprehensive webinar on this subject* ***Teaching physicians: Documentation best practices to avoid audit and minimize denials*** *is available as a CD from DecisionHealth at https://store.decisionhealth.com/Product.aspx?ProductCode=MPW-A2587CD-15.*

EHR

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"Today we're getting into what I'd call the sophisticated kinds of alerting capability," says Steve Dart, director of the