Documentation Tips:
Why good documentation matters and how to achieve it

By
Cherie Bennett, MD, FACP
Disclosures and Conflict of Interest Statement

- I like living in a rural area
- I have worked in rural healthcare for most of my career in Internal Medicine
- I spent 20 years doing traditional Internal Medicine in the hospital (including ICU), office and nursing home
- I now do outpatient Internal Medicine only
- I also serve on my hospital’s Medicare RAC committee and write our appeal letters

- I have no conflict of interests, no research and no ties to the pharmaceutical industry

Logansport Memorial Hospital
Rural Healthcare

83 Bed Hospital

6 bed ICU

15 Outpatient medical offices

Population: 17,780
Outline

• Documentation basics
  • Office
  • How documentation affects billing
  • Hospital
• Medicare RAC
• Medicare Advantage Plans
• Hospital Audit Cases from Medicare Advantage Audits
  • What are auditors looking for
  • How to improve hospital documentation
Elements of a detailed note

• Chief complaint
• History of Present Illness
• Review of Systems
• Combination of
  – Past medical history
  – Social history
  – Family history
• Physical Exam
• Assessment and Plan

Image Reference: https://www.harrietortiz.blogsport.com
History of Present Illness
(8 possible)

• Location
• Severity
• Timing
• Duration
• Quality
• Associated Signs and Symptoms
• Modifying factors
• Context

Reference: 1997 Documentation guidelines for evaluation and management services, History of present illness, page 7
History of Present Illness

Example: Chest Pressure

• Yesterday, a 63 year old male smoker had a 5/10 crushing substernal chest pressure radiating to left arm associated with diaphoresis while climbing a flight of stairs. Relieved by 1 sublingual nitro. Lasted 10 minutes.

  – Location: substernal
  – Severity: 5/10
  – Timing: yesterday
  – Duration: 10 minutes
  – Quality: crushing chest pressure
  – Modifying factors: relieved by nitro
  – Associated s/s: left arm, diaphoresis
  – Context: climbing a flight of stairs
History of Present Illness
Example: Chest Pressure

• **Yesterday**, a 63 year old male smoker had a **5/10 crushing substernal chest pressure** radiating to left arm associated with diaphoresis while climbing a flight of stairs. **Relieved by 1 sublingual nitro.** **Lasted 10 minutes.**

  – **Location**: substernal
  – **Severity**: 5/10
  – **Timing**: yesterday
  – **Duration**: 10 minutes
  
  – **Quality**: crushing chest pressure
  – **Modifying factors**: relieved by nitro
  – **Associated s/s**: left arm, diaphoresis
  – **Context**: climbing a flight of stairs
Review of systems
(14 possible)

• 1. Constitutional
• 2. Ears, nose, mouth and throat
• 3. Eyes (notice that eyes are a separate system from HEENT)
• 4. Neurologic
• 5. Psychiatric
• 6. Genitourinary
• 7. Integumentary (including breasts)

Reference: 1997 Documentation guidelines for evaluation and management services, Review of systems, page 8
Review of systems

• 8. Respiratory
• 9. Cardiovascular
• 10. Gastrointestinal
• 11. Musculoskeletal
• 12. Endocrine
• 13. Hematologic / lymphatic
• 14. Allergic / immunologic

Reference: 1997 Documentation guidelines for evaluation and management services, Review of systems, page 8
Review of systems Cardiac example

Positive

Negative

Reference: review of systems text box built for e-clinical at Logansport Memorial Hospital
# General Multisystem Physical Exam

<table>
<thead>
<tr>
<th>System</th>
<th>Components</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constitutional (any 3 vitals)</td>
<td>Neck</td>
</tr>
<tr>
<td>Eyes</td>
<td>Ears, Nose, Mouth and throat</td>
</tr>
<tr>
<td>Respiratory</td>
<td>Cardiovascular</td>
</tr>
<tr>
<td>Chest (breasts)</td>
<td>Skin</td>
</tr>
<tr>
<td>Gastrointestinal (abdomen)</td>
<td>Genitourinary</td>
</tr>
<tr>
<td>Lymphatic</td>
<td>Musculoskeletal</td>
</tr>
<tr>
<td>Neurologic</td>
<td>Psychiatric</td>
</tr>
</tbody>
</table>

Physical Exam
What do you need?

• Expanded problem focused exam, Office follow up (level 3)
  – 6 bullets from one or more organ systems

• Detailed exam, Office follow up (level 4)
  – 2 elements from six areas / systems
  – 12 bullets from two or more organ systems

• Comprehensive exam, History and physical / new office patient
  – 2 elements from 9 systems

Exam: Example of a complete gynecologic exam. General exam with a complete (gynecologic) organ system exam.

18 gynecologic areas examined
Vital Signs
BP 126/58, HR 68, Ht 71, Wt 141 lbs, BMI 19.66.

Examination
General Examination:
   GENERAL APPEARANCE: frail, thin, elderly male, cooperative, appears more unsteady on his feet than usual.
   EYES: extra ocular muscles intact (EOMI) bilaterally, pupils, equal, round, reactive to light and accommodation (PERRLA).
   HEENT: right ear wax., Left ear canal is normal, no oral lesions, normal left tympanic membrane.
   NECK no JVD, no thyromegaly, no bruit.
   CARDIOVASCULAR: regular rate and rhythm, no murmurs or gallops or rubs.
   RESPIRATORY: clear to auscultation bilaterally, good air exchange, no wheezes, rhonchi, rales.
   GASTROINTESTINAL: soft, non-tender/non-distended, bowel sounds present, no hepatosplenomegaly.
   NEUROLOGIC EXAM: unsteady on feet, leaning to left., awake & alert, decreased short-term memory, CNs II-XII grossly intact with the exception of decreased hearing, motor strength - 5/5 upper and lower extremities, finger-to-nose - normal, no tremor, normal speech, downgoing plantar reflex, delayed get up and go test with unsteady gait..
   SKIN: pink and warm.
   EXTREMITIES: bilaterally, no edema.
   PERIPHERAL PULSES: symmetrical bilateral., dorsalis pedis pulses palpable bilaterally.
   MUSCULOSKELETAL Normal muscle strength and tone.
   LYMPH NODES: no supraclavicular lymphadenopathy, no submandibular lymphadenopathy, no cervical adenopathy, no axillary adenopathy, no inguinal adenopathy.
   PSYCH Normal affect and mood.

Comprehensive exam: 2 bullets in 9 or more systems.
This is a 12 system exam.
Medicare Wellness
(this is an actual patient and NOT a template)

• BMI 19.66
• Frail thin elderly male,
• Right ear wax, decreased hearing
• Unsteady on feet, leaning to left, delayed get up and go test
• Decreased short term memory

• Alzheimer’s patient was admitted to the hospital that day with hyponatremia, new unsteady gait and an acute on chronic worsening of his memory loss.
Medicare Wellness vs. Gynecology exam

• Medicare wellness
  – Comprehensive exam: 9 systems with 2 bullets in each system (example: 12 systems)
  – Very few 80 year olds have a normal exam so the “normal” template does NOT work
  – Avoid using the physical exam “normal” templates in older, sicker patients.
  – Click individual system “normal” or abnormal values as you go
  – That is more accurate
  – In a legal situation, the electronic chart can be unbundled to show one click at a time how you entered the data.

• Gynecology (with uterus) template
  – Comprehensive exam: 8 systems with 2 bullets each & 1 complete genitourinary exam
  – Most 21 year olds have a normal exam so the “normal” template works
How H & P impacts billing level,
Office follow up

Image Reference: [www.kinardscreeksideah.com](http://www.kinardscreeksideah.com). Dog with Stethoscope
How history and physical exam impacts billing level, follow-up office

• Extended Problem Focused (99213), office note, follow-up
  – History of present illness: 1 to 3 elements
  – Review of systems: 1 pertinent system reviewed
  – No past medical, family or social history
  – Physical exam
    • At least 6 elements from one or more organ system
  – Decision making (low complexity)

Reference: https://emuniversity.com/initialHospitalServices.html, Level 3 established office visit (99213), expanded problem focused history, expanded problem focused physical exam
How history and physical exam impacts billing level, **follow-up office**

- Detailed *(99214)*, office note, follow-up
  - History of Present Illness (either):
    - 4 + elements or
    - 3 chronic problems
  - Review of systems: 2 to 9 systems reviewed
  - Past medical, family or social history
    - 1 pertinent element
  - Physical exam
    - 2 elements from 6 areas / systems
    - 12 elements from two organ systems
  - Moderate complexity decision making

Reference: [https://emuniversity.com/initialHospitalServices.html](https://emuniversity.com/initialHospitalServices.html), Level 4 Established office visit (99214), detailed history, detailed physical exam
How history and physical exam impacts billing level, **Office follow-up**

<table>
<thead>
<tr>
<th>Level</th>
<th>Level 3 (99213)</th>
<th>Level 4 (99214)</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of present illness</td>
<td>1 – 3 elements</td>
<td>4 elements or 3 chronic problems</td>
</tr>
<tr>
<td>Review of systems</td>
<td>1 pertinent system</td>
<td>2 – 9 systems</td>
</tr>
<tr>
<td>Past medical, social and family history</td>
<td>None</td>
<td>1 pertinent positive</td>
</tr>
<tr>
<td>Physical exam</td>
<td>6 elements from one or more organ systems</td>
<td>2 elements from 6 areas 12 elements from ≥ 2 systems</td>
</tr>
<tr>
<td>Medical decision making</td>
<td>Low complexity (1 stable chronic illness or 2 self limited problems)</td>
<td>Moderate complexity (new diagnosis, acute illness with systemic symptoms, 3 chronic illnesses)</td>
</tr>
</tbody>
</table>
Office new patient

Image Reference:  www.getcapables.com  Playing Doctor with Children
How history and physical exam impacts billing level, office new patient

- Detailed (99203), new patient, office
  - History of present illness (either):
    - 4 + elements or
    - 3 chronic problems
  - Review of systems: 2 to 9 systems reviewed
  - Past medical history, family history or social history
    - 1 pertinent element
  - Physical exam
    - 2 elements from 6 areas / systems
    - 12 elements from 2 or more systems
  - Low complexity decision making

Reference: [https://emuniversity.com/initialHospitalServices.html](https://emuniversity.com/initialHospitalServices.html), Level 3 new patient office visit (99203), detailed history, detailed physical exam
How history and physical exam impacts billing level, office new patient

- **Level 4, 99204, new patient, office**
  - History of present illness (either):
    - 4 + elements
    - 3 chronic problems
  - Review of systems: ≥ 10 systems
  - Past medical, social and family history:
    - Complete past medical, social and family history
  - Physical exam
    - 2 elements from 9 organ systems
  - Moderate complexity decision making

Reference: [https://emuniversity.com/initialHospitalServices.html](https://emuniversity.com/initialHospitalServices.html), level 4 new office visit (99204), comprehensive history, comprehensive physical exam
## How history and physical exam impacts billing level, **Office new patient**

<table>
<thead>
<tr>
<th>Level</th>
<th>Level 3 (99203)</th>
<th>Level 4 (99204)</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of present illness</td>
<td>4 elements or 3 chronic problems</td>
<td>4 elements or 3 chronic problems</td>
</tr>
<tr>
<td>Review of systems</td>
<td>2 – 9 systems</td>
<td>≥ 10 systems</td>
</tr>
<tr>
<td>Past medical, social and family history</td>
<td>1 pertinent positive</td>
<td>Complete past medical, social and family history</td>
</tr>
<tr>
<td>Physical exam</td>
<td>12 elements from ≥ 2 systems or 2 elements from six areas/systems</td>
<td>2 bullets from 9 organ systems</td>
</tr>
<tr>
<td>Medical decision making</td>
<td>Low complexity (1 stable chronic illness or 2 self limited problems)</td>
<td>Moderate complexity (new diagnosis, acute illness with systemic symptoms, 3 chronic illnesses)</td>
</tr>
</tbody>
</table>
How history and physical exam impacts billing level

• Notice that a **level 3 office new patient, 99203**, is basically the same as a **level 4 established patient, 99214**.

• The **office level 4 new patient**, is basically a **Level 1 Hospital History and Physical**.
How H & P impacts billing level,
Initial hospital care

Reference: www.blog.lakeviewhospital.com. Hospital for Heart Attack Patient
How H & P impacts billing level,
Initial hospital care

• Level 1 (99221), Initial hospital care
  – HPI: 4 + elements or 3 chronic problems
  – Review of systems: 2 – 9 systems
  – Past medical, family or social history:
    • 1 pertinent element from either past medical, family or social history
  – Physical exam (choose one)
    • 12 bullets from ≥ 2 systems
    • 2 elements from 6 areas / systems
  – Straightforward or low complexity decision making

Reference: https://emuniversity.com/initialHospitalServices.html, Initial Hospital Care, detailed history, detailed physical exam
How H & P impacts billing level, Initial hospital care

• Level 2 (99222), Initial hospital care
  – HPI: 4 + elements or 3 chronic problems
  – Review of Systems: ≥ 10 systems reviewed
  – Complete past history, family history and social history
  – Physical exam
    • At least 2 elements from 9 organ systems
  – Moderate complexity decision making

Reference: https://emuniversity.com/initialHospitalServices.html, Initial Hospital Care, comprehensive history, comprehensive physical exam
How H & P impacts billing level, Initial hospital care

• Comprehensive (99223), Initial hospital care
  – HPI: 4 + elements or 3 chronic problems
  – Review of systems: ≥ 10 systems reviewed in review of systems
  – Complete past history, family history and social history
  – Physical exam
    • At lease 2 elements from 9 organ systems
  – High complexity decision making

Reference: https://emuniversity.com/initialHospitalServices.html, Initial Hospital Care, comprehensive history, comprehensive physical exam
How H & P impacts billing level,
Initial hospital care

• The *only difference* between a level 2 and 3 new hospital patient history and physical is:
  – *Medical decision making*
    • Level 1: low complexity
    • Level 2: moderate complexity
    • Level 3: high complexity
• The history of present illness is the same
• The ROS, past medical, social and family history is the same
• The physical exam is the same
## Low Complexity Medical Decisions

<table>
<thead>
<tr>
<th>Presenting problem(s)</th>
<th>Diagnostic procedures ordered</th>
<th>Management options selected</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 or more self limited or minor problems</td>
<td>Pulmonary function tests or other physiologic non stress tests</td>
<td>Over the counter medication</td>
</tr>
<tr>
<td>1 stable chronic illness (well controlled HTN, non-insulin dependent DM, cataract, BPH)</td>
<td>Non-cardiac imaging with contrast (barium enema)</td>
<td>Minor surgery without risk factors</td>
</tr>
<tr>
<td>Acute uncomplicated illness/injury (cystitis, allergic rhinitis, simple sprain)</td>
<td>Superficial needle biopsies Arterial blood gas Skin biopsy</td>
<td>Physical or occupational therapy IV fluids without additives</td>
</tr>
</tbody>
</table>

Reference: Department of Health and Human Services; Centers for Medicare & Medicaid Services; Medicare Learning Network; Evaluation and Management Services, pg. 13 & 84
## Moderate Complexity Medical Decisions

<table>
<thead>
<tr>
<th>Presenting problem</th>
<th>Tests ordered</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 or &gt; chronic illness + mild exacerbation, progression, or side effects of treatment</td>
<td>Physiologic stress test (cardiac or fetal)</td>
<td>Minor surgery with risk factors</td>
</tr>
<tr>
<td>2 or &gt; chronic stable illnesses</td>
<td>Diagnostic endoscopies without risk factors</td>
<td>Elective major surgery without risk factors</td>
</tr>
<tr>
<td>Undiagnosed new problem with uncertain prognosis, example: breast lump</td>
<td>Deep needle / incisional biopsy</td>
<td>Prescription drug management</td>
</tr>
<tr>
<td>Acute illness with systemic symptoms</td>
<td>Cardiovascular image with contrast and no risk factor</td>
<td>Therapeutic nuclear med Rx</td>
</tr>
<tr>
<td>Acute complicated injury</td>
<td>Obtain fluid from body cavity (LP, thoracentesis)</td>
<td>IV fluids with additives</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Closed fx w/o manipulation</td>
</tr>
</tbody>
</table>

Reference: Department of Health and Human Services; Centers for Medicare & Medicaid Services; Medicare Learning Network; Evaluation and Management Services, pg. 13 &
# High Complexity Medical Decisions

<table>
<thead>
<tr>
<th>Presenting problem</th>
<th>Tests ordered</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 or more chronic illness with severe exacerbation, progression or side effects of treatment</td>
<td>Cardiac image with contrast with identified risk factors</td>
<td>Elective major surgery with risk factors</td>
</tr>
<tr>
<td>Acute or chronic illness or injuries w/ threat to life or function (acute MI, PE, severe respiratory distress, acute renal failure...)</td>
<td>Cardiac electrophysiology tests</td>
<td>Emergency major surgery</td>
</tr>
<tr>
<td>Abrupt change in neurologic status (seizure, TIA, weakness, sensory loss)</td>
<td>Diagnostic endoscopies with risk factors</td>
<td>Parenteral (NOT oral) controlled substances</td>
</tr>
<tr>
<td></td>
<td>Discography</td>
<td>Drugs requiring intensive toxicology monitoring</td>
</tr>
<tr>
<td></td>
<td></td>
<td>DNR/ de-escalate care decision due to poor prognosis</td>
</tr>
</tbody>
</table>

Reference: Department of Health and Human Services; Centers for Medicare & Medicaid Services; Medicare Learning Network; Evaluation and Management Services, pg. 13 & 84
Time Matters

• Whenever you spend more than 30 minutes on a given day in direct patient care, document it
• This includes
  – Admission, discharge, critical care,
  – care during hospital stay, office care
• This includes
  – Direct care provided to patient
  – Time spent discussing care with patient and family
  – Interpreting x-rays and labs,
  – Drawing blood, doing an ABG, NG tube
  – Managing ventilator, transcutaneous pacemaker

Image Reference:  www.memoriesproject.com
Reference 2:  https://emuniversity.com/99292.html  Coding based on time
Critical Care

• Time spent providing critical care
  • Document minutes spent providing critical care
  • ≥ 30 minutes is an additional billing code
  • Additional 30 minutes beyond that is an additional billing code
  • ≥ 75 minutes is an additional billing code

• Must require advanced medical technology

• Critical care defined by severity of illness not by location
  • Example: Code blue in the lobby
  • Example: not all ICU patients are critically ill

Image Reference: www.memoriesproject.com
Reference 2: https://emuniversity.com/99292.html 99291, 99292
How H & P impacts billing level, Hospital follow up

How H & P impacts billing level,

Hospital follow up

• **Level 1 (99231), hospital follow up**
  – HPI: 1 to 3 elements
  – No review of systems
  – No past medical history, no family history, no social history
  – Physical exam
    • 1 – 5 bullets from one or more organ system
  – Medical decision making: straightforward / low
  – Time: 15 minutes

Reference: [https://emuniversity.com/hospitalprogressnotes.html](https://emuniversity.com/hospitalprogressnotes.html), subsequent hospital care
How H & P impacts billing level, Hospital follow up

- **Level 2 (99232), hospital follow up**
  - HPI: 1 to 3 elements
  - **Review of systems: 1 system reviewed**
  - No past medical history, no family history, no social history
  - Physical exam
    - 6 elements from one or more organ systems
  - **Medical decision making: moderate**
  - **Time: 25 minutes**

Reference: [https://emuniversity.com/hospitalprogressnotes.html](https://emuniversity.com/hospitalprogressnotes.html), subsequent hospital care
How H & P impacts billing level, Hospital follow up

- **Level 3 (99233), hospital follow up**
  - HPI: 4 + elements or 3 chronic problems
  - Review of systems: 2 to 9 systems reviewed
  - 1 pertinent past history, family history or social history
  - Physical exam
    - 12 elements from ≥ 2 organ systems
    - 2 elements from 6 areas / systems
  - Medical decision making: high complexity
  - Time: 35 minutes

Reference: [https://emuniversity.com/hospitalprogressnotes.html](https://emuniversity.com/hospitalprogressnotes.html), subsequent hospital care
# How H & P impacts billing level, Hospital follow up

<table>
<thead>
<tr>
<th>Level</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of present illness</td>
<td>1-3 elements</td>
<td>1-3 elements</td>
<td>4 elements or 3 chronic problems</td>
</tr>
<tr>
<td>Review of systems</td>
<td>none</td>
<td>1 system reviewed</td>
<td>2 – 9 systems reviewed</td>
</tr>
<tr>
<td>Past medical, social and</td>
<td>none</td>
<td>none</td>
<td>1 pertinent past medical, social or family</td>
</tr>
<tr>
<td>family history</td>
<td></td>
<td></td>
<td>history</td>
</tr>
<tr>
<td>Physical exam</td>
<td>1-5 bullets from 1 or more organ systems ²</td>
<td>6 bullets from one or more organ systems ³</td>
<td>2 elements from 6 areas/systems</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>12 elements from ≥ 2 systems ⁴</td>
</tr>
<tr>
<td>Decision making</td>
<td>Low complexity</td>
<td>Moderate complexity</td>
<td>High complexity</td>
</tr>
<tr>
<td>Time</td>
<td>15 minutes</td>
<td>25 minutes</td>
<td>35 minutes</td>
</tr>
</tbody>
</table>

Reference 1: [https://emuniversity.com/hospitalprogressnotes.html](https://emuniversity.com/hospitalprogressnotes.html), Hospital Progress Notes
Reference 2: [https://emuniversity.com/hospitalprogressnotes.html](https://emuniversity.com/hospitalprogressnotes.html), Problem focused history
Reference 3: [https://emuniversity.com/hospitalprogressnotes.html](https://emuniversity.com/hospitalprogressnotes.html), Expanded problem focused history
Reference 4: [https://emuniversity.com/hospitalprogressnotes.html](https://emuniversity.com/hospitalprogressnotes.html), Detailed physical exam
Mechanical Ventilation
Time matters on the vent

• Mechanical Ventilation
  – Document when started
  – Document when extubated
  – Document length of time on the ventilator

Mechanical Ventilation ICD-10 codes are based on time²
  less than 24 hours
  24 – 96 hours
  more than 96 hours (4 days)

Image Reference 1: www.memoriesproject.com
Reference 2: http://blr.hcpro.com/content.cfm?content_id=315061, JustCoding News: Inpatient, April 8, 2015, Coding clinic highlights mechanical ventilation, principal procedure sequencing
Medicare Recovery Audit Contractors (RAC)
Medicare Recovery Audit Contractors

Regions 1 – 4 RACs do “post payment review to identify and correct Medicare claims specific to Part A and Part B”

Region 5 RAC “will be dedicated to review of Durable Medical Equipment, Prosthetics, Orthotic, and Supplies (DMEPOS) and Home Health / Hospice”

Medicare Recovery Audit Contractors (RAC)

Medicare RAC Program Development Timeline

- 2005  Fee for service RAC pilot program initiated
- 2005 – 2008
  - $900 Million in overpayments returned to Medicare
  - $38 million in underpayments to healthcare providers
- 2009  Fee for Service RAC implemented nationwide
- 2010  Affordable Care Act expands RAC to Medicare Parts C & D
- 2011  CMS awards Part D RAC contract
- 2012  First Medicare Part D RAC Audits conducted
- 2014
  - $2.57 Billion in improper payments returned to Medicare

Reference 2: https://www.healthicity.com/blog/recovery-audit-contractor-rac-part-1-the-history-of-rac
Traditional Medicare Recovery Audits (RAC) Appeals
Levels 2 – 5 are Independent Reviews

Level 1: Medicare Administrative Contractor
Level 2: Qualified Independent Contractor
Level 3: Administrative Law Judge
Level 4: Medicare Appeals Council
Level 5: Judge in U.S. District Court

Traditional Medicare vs. Medicare Advantage

• Traditional Medicare
  – Parts A & B
  – Parts A & B & D (prescriptions)
  – Parts A & B & Medicare supplement plan
  – Parts A & B & D (prescriptions) & Medicare supplement plan

• Medicare Advantage
  – Part C (covers part A & B)
  – Part C (covers part A & B) & D (prescriptions)
  – Part C (covers part A & B) & limited part D (prescriptions)

Reference 1: https://hellomedicare.com/medicare-101/
Reference 2: https://www.plansforseniors.com/medicare-advantage
Medicare Advantage (Part C)

• Private insurance companies contracted by Medicare
  – Covers Original Medicare Part A (inpatient) & B (outpatient) services \(^1,^2\)
  – May also cover vision, hearing, dental and wellness \(^1\)
  – Created in 1997 as “Medicare + Choice” \(^2\)
  – Renamed “Medicare Advantage” in 2003 \(^2\)

• Different types of plans \(^1\)
  – HMO (health maintenance organization)
  – PPO (preferred provider organization)
  – PFFS (private fee for service)
  – SNP (special needs plans)

Reference 1: [https://www.plansforsenior.com/medicare-advantage](https://www.plansforsenior.com/medicare-advantage)
Medicare Advantage Plans
Administered by private insurance companies

• Your hospital’s contract determines your rights in appeal.
• Without a contract with a specific Medicare Advantage Plan
  – Must pay Medicare rates
  – Entitled to internal appeal
  – Entitled to independent appeal
• With a contract
  – Insurer can pay below the Medicare rate
  – No appeal rights – you appeal to the plan (that denied you)
  – No independent review
  – Some plans are using RAC contractors for post-payment reviews

Medicare vs. Medicare Advantage Audits

Medicare Parts A & B Appeals Process

- Level 1: MAC
- Level 2: Independent Organization
- Level 3: Office of Medicare Hearings and Appeals
- Level 4: Medicare Appeals Council
- Level 5: Federal Court

Medicare Advantage

Often only get 1 level of appeal which is not independent unless you contracted for a different appeals process

5 levels of appeal (4 are independent)
Denials
Malnutrition and morbid obesity

Tyrannosaurus Rex

Sumo Wrestlers

Image Reference:  https://www.dinocreta.com/extreme-dinosaurs/t-rex-fossils-
fth tl

Malnutrition Payment Denial

• 76 year old female with a history of lung cancer.
• s/p right upper lobe resection several years ago.
• Found lethargic.
• Weight = 97.4 pounds, BMI = 16.7
• Physical exam (hospital): well developed, well nourished, alert, oriented, cooperative...
• (ER): well developed, well nourished; disoriented to time/place...
Malnutrition Denial

• Diagnosis #7 (day 3 of hospital stay): malnutrition.
• Status: chronic.
• Assessment and plan:
  • severe protein calorie malnutrition.
  • Encourage by mouth intake.
  • Will start on ensure supplements.
• Physical exam (day 3): thin, underweight
Malnutrition Denial Letter

• “Diagnosis of malnutrition is evaluated according to a combination of consensus guidelines cited below, taking into account degree of weight loss, body mass index, characteristic clinical signs and laboratory findings”.
• Patient presented with a BMI of 18 (our chart says 16.7).
• Albumin = 3.9 (normal range 3.4 – 4.9)
• No weight loss documented
• Physical exam: “well developed, well nourished”, normal skin exam.

• Denial letter: $4,067.79
Malnutrition denial, Problem Solving

• Case we **LOST** was presented at hospitalist meeting (**$4,067.79**)
  • “well developed, well nourished” is part of the canned H&P template
    • “well developed, well nourished” **NEVER** helps us
    • We deleted “well developed, well nourished” from physical exam template.
  
• Talked about documenting
  • Weight loss,
  • Physical appearance of patient in detail.
  
• Discussed consulting the dietician and treating malnutrition

• Internal chart audits on malnutrition cases

• **Documentation contest**
  • $5 gift card to coffee shop and hospital cafeteria
  • Winner announced at hospitalist meeting (public praise)

• **Template to document malnutrition developed**
• History and Physical
  • Mother added protein powder to his normal oatmeal and other intake to help with nutritional needs.
  • Not a good candidate for a G-tube due to contractures and potential for complications
• Review of systems
  • Denies appetite changes
• Physical exam
  • Poorly developed, cachectic, contractured, mucosa is slightly dry.
• Diagnosis: Moderate protein-calorie malnutrition
  • Mother has recently been adding protein powder to patient’s diet.
  • Significant improvement in patient’s total protein and albumin levels.
• The only correction I would make is to add the BMI = 10.7
Malnutrition: How we built our documentation template
What we were looking for?

- ICD-10 BMI definition for malnutrition is **BMI < 19**
- The American Academy of Nutrition and Dietetics defines malnutrition as at least **2 of the following 6 items:**
  1. Insufficient energy intake
  2. Weight loss
  3. Loss of muscle mass
  4. Loss of subcutaneous fat
  5. Localized or generalized fluid accumulation that may sometimes mask weight loss (**possible exception to BMI < 19**)
  6. Diminished functional status as measured by hand grip strength

Malnutrition: How we built our documentation template

Non-medication treatment

• **Dietician**
  1. food and nutrient delivery
  2. nutrition education
  3. nutrition counseling
  4. coordination of nutrition care

• Meta-analysis in hospital hip fracture patients receiving organized nutritional care showed 24% reduced mortality

• Even larger mortality reduction if BMI < 20

• **Nutritional supplements**

• **Multivitamin**

Reference 1: Journal of the Academy of Nutrition and Dietetics. September 2013, Volume 113, Issue 9, Pages 1219 - 1237
Reference 2: UpToDate: Geriatric nutrition: Nutritional issues in older adults, page 11
Malnutrition: How we built our documentation template
Medications to treat malnutrition

• Megestrol acetate (Megace):
  • weight gain and increased appetite
  • Anorexia, cachexia, cancer, AIDS patients

• Dronabinol (Marinol, Syndros):
  • Improve appetite in AIDS patients
  • Less effective than megestrol in cancer patients

• Mirtazapine (Remeron)
  • Treats combined depression and weight loss in older adults

Reference 1: UpToDate: Geriatric nutrition: Nutritional issues in older adults, page 11-12
Malnutrition and Morbid Obesity
Adult BMI Categories

BMI < 19  malnutrition
BMI of 20 to 24  normal
BMI of 25 to 29  overweight
BMI of 30 to 39  obesity
BMI over 40  morbid obesity
(BMI divided by 10 up to 70)

Image Reference 2:  www.a3bi.com
Malnutrition and Morbid Obesity

• Our 83 bed hospital lost $4,067.79 on 1 case of poorly documented malnutrition.
• Recently a 900 bed teaching hospital in the South was fined $1.4 million by Medicare for incorrect coding and documentation of malnutrition.¹

• We also had a morbid obesity denial and are working on a template²
  • In the good old days, the sumo wrestler was morbidly obese based on height and weight.
  • Now, we have to look at (and document):
    • Extra resources needed to care for the patient (larger beds, assistance with moving)
    • Added risk of infection
    • Excess weight preventing normal activity
    • Excess weight affecting physiologic function
    • Obesity related health conditions and comorbidities

Reference 2: https://www.capstoneperformancesystems.com/articles/documenting-and-coding-for-morbid-obesity-hcc-22/
Acute and Chronic hypoxemic respiratory failure

Image Reference:  https://Vetsnowreferrals.com:  Aspiration Pneumonia Radiograph
Acute respiratory failure in a “COPD patient” denial

• 65 year old metastatic esophageal cancer patient
  – Receiving chemotherapy with a taxane derivative, Docetaxel (Taxotere)
  – Receiving radiation therapy
• Carried a diagnosis of COPD
  – Never had any coughing or wheezing before.
  – No prior COPD exacerbations.
  – Was NOT on home oxygen
Acute respiratory failure in a “COPD patient” denial

- In the emergency room,
  - oxygen saturation 84% on room air,
  - pulse = 133,
  - temperature = 99.2,
  - respiratory rate of 20.
  - WBC = 1.5 with 38% neutrophils, 3 bands, 9 lymphocytes, 44 monocytes,
  - Hgb = 10.6, Hct = 31.7.
- ABG done the following morning on 2 liters of oxygen
- pH = 7.483, PaCO2 = 29.4, HCO3 = 21.6, pO2 68.9, O2 saturation = 95%.

- Estimated PaO2 for an oxygen saturation of 84% is PaO2 = 49 mmHg
- Expected normal ABG
  - pH = 7.35 – 7.45, PaCO2 = 35 – 45, HCO3 = 21 – 27,
  - Normal PaO2 has not been defined but a reasonable value is resting PaO2 > 80 and SaO2 > 95% unless new values are substantially different than prior values

Reference 2: Theodore, AC; Manaker, S; Finlay, G; Arterial blood gases, page 9
Acute respiratory failure denial for a “COPD patient”

• Pulmonary
  – COPD
    • mild and unlikely to have caused the respiratory symptoms
  – Acute interstitial pneumonitis starting 2 weeks prior to admission.
    • Likely due to Taxane derivative, Docetaxel (Taxotere)
    • Not due to radiation due to the time course.

• Patient treated with:
  – Glucocorticoids, antibiotics and bronchodilators.
  – Taxane derivative, Docetaxel (Taxotere) was discontinued.

• Patient was discharged to home on:
  – New Rx for home oxygen (on room air, pulse oximetry with exertion was 83%)
  – High dose prednisone (not the usual COPD dose).
Acute respiratory failure denial

• Denial letter for acute respiratory failure stated:
  – Patients with COPD have:
    • Chronically low PaO2
    • Chronically high PaCO2
  – Diagnosis of respiratory failure
    • Based upon the degree of change from the usual state of the individual and not simply on PaO2 and/or PaCO2
  – A patient with COPD
    • PaCO2 may be near 50 mm Hg with normal pH due to chronic hypercapnia.
    • Drop in Pa O2 ≥ 10 – 15 mm Hg indicates acute respiratory failure.
  – No acute signs of respiratory failure such as work as work of breathing or accessory muscle use
Acute respiratory failure denial letter, $4088.33

• Denial references
  – Coding clinic, third quarter 1988, page 7, Respiratory failure-guidelines
  – Harrison’s Principles of Internal Medicine, 18th edition, McGraw Hill, New York, 2012 (the ENTIRE textbook, no pages were referenced)

• We lost this denial and similar denials on appeal
• They continue to use a 1988 coding clinic reference to deny all acute respiratory failure in COPD patients without their ABG standards.
• No pulse oximetry data was used or considered.
Acute respiratory failure denial, $4088.33

• **ABG on 2 Liters of oxygen 1 day after admission** (in a patient that had never been on home oxygen was cited as being a *normal ABG*)

• **Pulse oximetry of 84% on room air was ignored.**

• Acute respiratory failure definition \(^1\)
  – \(pO2 < 60 \text{ mm Hg or SpO2} < 91\% \text{ breathing room air}\)
  – \(pCO2 > 50 \text{ and pH} < 7.35\)
  – \(P/F \text{ ratio (pO2 / FIO2)} < 300\)
  – \(pO2 \text{ decrease or pCO2 increase by 10 mm Hg from baseline (if known)}\)

Reference 1: ACP Hospitalist, 2013, Volume 10, Coding Corner, page 2
Acute respiratory failure problem solving

• We are formally complaining to Medicare about this insurance company for:
  – Using a 30 year old reference (1988 Coding Clinic) and a textbook (without pages cited)
  – Denying acute respiratory failure repeatedly in COPD patients
  – Using strict ABG standards even in patients not previously on home oxygen
  – Refusing to use markedly abnormal pulse oximetry data

• Our strategy
  – Recognized that the only way we can win these cases is by doing ABGs
  – Talked to multiple disciplines
    • Emergency room
    • Hospitalists
    • Nursing
  – Started an ABG protocol
    • Automatically do an ABG if we have a new pulse oximetry value of ≤ 85%.
    • We set the criteria low to avoid unnecessary ABGs.

Reference 1: Coding clinic, third quarter 1988, page 7, Respiratory failure-guidelines
Sepsis – the Rules are Changing
Old (SIRS) vs New (SOFA)

Gram Positive Bacteria vs. Gram Negative Bacteria

Image Reference: https://www.differencebtw.com
Sepsis – the Rules are Changing
Old (SIRS) vs New (SOFA)

• After criteria for Sepsis changed from SIRS to SOFA, 1,2,3
  – We received several denials for Sepsis written using SIRS criteria.
  – We won a SIRS denial on appeal showing that the SOFA score was 6

• Educated our hospitalists and nurse practitioners on SOFA criteria
  – Case presentations of denials in 2 different hospitalist meetings
  – 2 different educational presentations on SOFA

• Created SOFA badge cards

• Built a SOFA template for our computer

SOFA = 2 = sepsis

- Respiratory: ABG & FIO2; +/- BIPAP or mech vent
- Low blood pressure (mean arterial pressure)
- Platelets < 150
- Bilirubin > 1.2 mg/dL
- Mental status change (Glasgow coma scale)
- Creatinine > 1.2 or urine output < 200 ml/day
- Septic shock = SOFA = 2 with
  - Lactic acid > 2
  - Needing vasopressors despite adequate fluid bolus

Reference: https://www.openclipart. Colored line art sofa
Ref: UpToDate. Predictive scoring systems in the Intensive Care Unit
SOFA CALCULATIONS

RESPIRATORY SOFA SCORE: ¹

<table>
<thead>
<tr>
<th>PaO2 / FiO2</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt; 400</td>
<td>0</td>
</tr>
<tr>
<td>300 – 400</td>
<td>1</td>
</tr>
<tr>
<td>≤ 300</td>
<td>2</td>
</tr>
<tr>
<td>101 – 200 with vent support</td>
<td>3</td>
</tr>
<tr>
<td>≤ 100 with ventilator support</td>
<td>4</td>
</tr>
</tbody>
</table>

MEAN ARTERIAL PRESSURE ²

\[
\text{MAP} = \frac{\text{SBP} + (2 \times \text{DBP})}{3}
\]

SBP = Systolic BP
DBP = Diastolic BP

SOFA = 2 = Sepsis

- Respiratory: ABG & FIO2; +/- BIPAP or mechanical ventilation
- Low blood pressure (MAP<70)
- Platelets < 150
- Bilirubin > 1.2 mg/dL
- Mental status change (Glasgow coma scale)
- Creatinine > 1.2 or urine output < 200 ml/day
- Septic shock = SOFA = 2 with
  - Lactic acid > 2
  - Needing vasopressors despite adequate fluid bolus

Reference 1: UpToDate: Calculator: sequential Organ Failure Assessment: SOFA score in adults
Medical Student and Hospitalist Sepsis Documentation Contest

• Sepsis History:
  – found in pool of vomit,
  – decline in cognitive function,
  – fever, hypotension, increased respiratory rate,
  – BIPAP started. Admit to ICU.

• Exam:
  – somnolent, not oriented to space, following commands.
  – Glasgow coma score 13
  – Mucous membranes are dry.
  – Labored respirations with retractions, on BIPAP. Diffuse wheezes and diminished breath sounds.

• Assessment: Sepsis, SOFA score 9

Image Reference: https://www.thebumpyride.blogspot.com
Medical Student and Hospitalist
Documenting with Sepsis Template

<table>
<thead>
<tr>
<th>Glasgow Coma Scale</th>
<th>Response (Comments)</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glasgow Coma Scale Eye Opening</td>
<td>To Voice</td>
<td>3</td>
</tr>
<tr>
<td>Glasgow Coma Scale Motor</td>
<td>Obey Commands</td>
<td>6</td>
</tr>
<tr>
<td>Glasgow Coma Scale Verbal</td>
<td>Confused</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>13</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sequential Organ Failure Assmt</th>
<th>Response (Comments)</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glasgow Coma Scale</td>
<td>13-14</td>
<td>1</td>
</tr>
<tr>
<td>SOFA Respiratory</td>
<td>PaO2/FiO2 &lt; or = 300</td>
<td>2</td>
</tr>
<tr>
<td>SOFA Platelets</td>
<td>&gt; 150,000</td>
<td>0</td>
</tr>
<tr>
<td>SOFA Bilirubin</td>
<td>&lt; 1.2</td>
<td>0</td>
</tr>
<tr>
<td>SOFA Blood Pressure</td>
<td>On Norepinephrine &gt; 0.1 mcg/min</td>
<td>4</td>
</tr>
<tr>
<td>SOFA Renal Function</td>
<td>Creatinine = 2-3.4</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>9</td>
</tr>
</tbody>
</table>

Image Reference: [https://www.thebumpyride.blogspot.com](https://www.thebumpyride.blogspot.com)
New Logansport Memorial Hospital
Cancer Care Center
Cherie Bennett, MD, FACP

Logan Internists
1201 Michigan Ave
Suite 170
Logansport, IN 46947

Office Phone: 574-722-4331
Cell phone: 574-702-2184
Fax: 574-722-6856
Email: cbennett@LogansportMemorial.org