

D.12 HEALTH INFORMATION MANAGEMENT (CM 136-05, JULY 28, 2014)

VA WESTERN NEW YORK HEALTHCARE SYSTEM

July 28, 2014

CENTER MEMORANDUM NO. 136-05

HEALTH INFORMATION MANAGEMENT

1. **PURPOSE**: To state VA Western New York Healthcare System (VAWNYHS) policy with regard to the adoption of the Center Medicare & Medicaid Management Services (CMS) 1997 Coding Guidelines. To ensure standard data collection for medical coding policy and procedures in the performance of both inpatient and outpatient services rendered. This memorandum applies to all Care/Service Lines.

2. **POLICY**: All services will use the 1997 version of the CMS Evaluation and Management coding guidelines when medical coding and in the performance of physician audits.

3. **SCOPE**: Clinical coding plays a vital role in the revenue cycle including Third Party and VERA, research, patient safety initiatives, healthcare quality measures, disease management, workload tracking and reporting. The level of E&M code reported will be supported by the clinical documentation in the patient's medical record. All providers and staff will follow current Common Procedural Terminology (CPT) coding conventions and current CMS and Trailblazer 1997 E&M Coding Guidelines.

- 1997 E/M Guidelines from Trailblazers
- Evaluation & Management Homepage for additional information

4. **RESPONSIBILITIES**:

- A. Providers are responsible for accurate and complete documentation of services rendered, including conditions and/or symptoms addressed, physical examination findings, assessment of the patient, treatment plans, as well as referrals for ancillary tests/procedures, according to the established medical record documentation guidelines.
- B. The primary provider is responsible for the selection of the appropriate procedure and diagnostic codes for each encounter. Diagnosis and procedure codes selected must be supported by the documentation in the medical record in order to satisfy medicolegal requirements and to determine medical necessity.
- C. Designated HIM staff are responsible for validating code selection based on clinical documentation in the patient's medical record on pre-selected clinics. Coders are also responsible for consulting with physicians for clarification when there is a conflict or ambiguous documentation in the medical record through the Query process.

5. **DEFINITIONS**:

- A. **E&M Codes**: A subsection of CPT codes used to report patient evaluation and management services, such as those provided during outpatient office visits, inpatient hospital visits and consultative visits. Codes are based on type of visit and level of service rendered (based on medical documentation).
- B. **Established Patient**: A patient who has received professional services from the same physician, the same specialty group, or the same healthcare system within the past three years.
- C. **New Patient**: A patient who has not received any professional services from the same physician, the same specialty group or the same healthcare system within the past three years.

- D. Consultations: A type of service provided by a physician whose advice regarding evaluation and management of a specific problem is requested in writing by another physician or other appropriate source. The consultant may initiate diagnostic or therapeutic services. The opinion rendered and services ordered/performed must be documented in the patient's medical record and communicated back to the requesting entity or providers relative to the patient's care. When coordination of care dominates more than 50 percent of the total visit, time spent with the patient can be considered the key or controlling factor to qualify for a particular level of E&M service. The provider must document either the total face-to-face time spent with the patient or the total unit/floor time spent (if inpatient), in addition to the time spent in coordination of care activities and the specific issues addressed.
- E. Counseling: Discussion between the physician and the patient or family regarding his condition, prognosis and treatment options. When counseling dominates more than 50 percent of the total visit, time spent with the patient can be considered the key or controlling factor to qualify for a particular level of E&M service. The provider must document the total time spent with the patient, the time spent in counseling, and the specific issues discussed.
- F. Face-to-Face Time: Time that the physician spends face-to-face with the patient and/or family in the office or other outpatient setting. This includes the time the physician spends in obtaining a history, performing an examination, assessing the patient's condition, planning treatment options, and counseling. Pre- and post-encounter time (such as reviewing records, arranging for further services, telephonic communications) are not included in the time component of E&M code selection in the outpatient setting.
- G. Unit/Floor Time: Time that the physician spends on the patient's hospital unit and at the bedside rendering services for that patient. This includes the time in which the physician establishes and/or reviews the patient's chart, examines the patient, writes notes and communicates with other professionals and the patient's family.

6. **PROCEDURES**: The goals of the guidelines are to assist in the standard documentation by providers contained within the clinical medical record:

- A. Definitions and documentation guidelines for the three key components of Evaluation and Management services and for the visits which consist predominately of counseling or coordination of care. [History, examination and medical decision making]. The documentation of each patient encounter should include; reason for the encounter and relevant history and physical examination findings and prior diagnostic test results; assessment and clinical impression or diagnosis; plan of care and date and identity of the provider. If not documented, the rationale for ordering diagnostic and ancillary services should be inferred. Include past and present pertinent diagnoses, health risk factors, patient progress and response to treatment and revision of diagnosis.
- B. Health record should substantiate the CPT evaluation and management coding by the documentation in the medical record.
- C. Documentation to service as communication and continuity of care among physicians and other health care professionals involved in patient care.
- D. Assure the accuracy and timely coding of encounters for service rendered. Inpatient: coding must be completed and transmitted to the VA Corporate Franchise Data Center (CFD) Patient Treatment File (PTF) no later than the 7th calendar day following the patient's discharge. Outpatient: coding and data corrections are to be completed and transmitted to CFD National Patient Care Database no later than 7 calendar days after the outpatient visit. Data not received by the 7th calendar day after the event (discharge or visit) may not be included in the statistical reports.

- E. Serve as a legal document to verify the care provided.
 - F. Provide physicians, claims reviewers and auditors with advice about preparing or reviewing documentation for Evaluation and Management services.
 - G. In providing consistent clinical descriptors and definitions contained in American Medical Association – Current Procedural Terminology.
 - H. Minimize any changes in clinical record-keeping policy.
 - I. Would interpret and apply standards uniformly by users including providers and coders.
7. **REPORTING:** Through auditing, the procedure of review to evaluate the accuracy of information.
- A. Internal audits performed by designated VISN 2 individuals and/or contracted coding vendor/consultants.
 - B. All services provided must be monitored for quality including, but not limited to completeness, timeliness and accuracy as established by Network 2 Health Information Documentation Standards; Memorandum Number 10N2-116-10.
 - C. Evaluation and Management Reason for change audit to assure 95% coding accuracy rate of providers.
 - D. Reason not billed audit to assure provider documentation, resident supervision and student documentation is standard has been met.
8. **REFERENCES:**
- A. American Medical Association, HCPCS, current edition
 - B. Ingenix Coder's Desk Reference for Procedures, current edition
 - C. Ingenix HCPCS Level II, current edition
 - D. VHA Reasonable Charge and Billing Procedures Guide, current edition
 - E. VHA Handbook for Coding Guidelines, current edition
 - F. Network 2 Health Information Management Documentation Standards
9. **RESCISSION:** Center Memorandum 136-05 dated February 14, 2011
10. **AUTOMATIC REVIEW DATE:** July 1, 2017
11. **FOLLOW-UP RESPONSIBILITY:** Documentation and Quality Education Specialist

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