



West Virginia University  
Physicians of Charleston

2010 Resident  
Chart Documentation & Compliance  
Annual Update

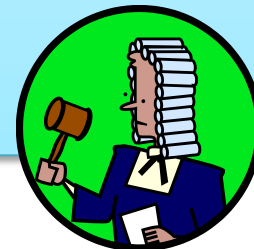
Summer 2010

# Legal Stuff




*The information provided here is being provided by a non-lawyer and should not be construed as legal advice. Each provider is ultimately responsible for bills submitted under their NPI numbers. For specific legal guidance on any billing issue, consult with your Medicare Carrier and/or your health care attorney.*

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# Why the Focus on Compliance & Accurate Documentation & Coding?

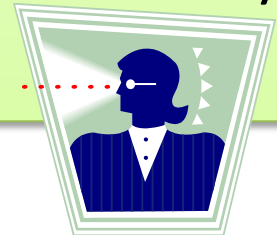
- Ongoing substantial governmental anti-fraud/abuse initiatives are occurring in both the private and public sector, including the academic setting 
- 2010 healthcare reform legislation provides increases in funding for anti-fraud investigations/prosecutions
- DHHS and the OIG have nearly doubled the amount overpayments recovered in the past 5 years

The government is watching closely! A robust and effective compliance program is a necessity!!



# Compliance Program Overview

- The WVUPC compliance program was adopted by the Board of Directors in 2004
- The program is designed to provide compliance assistance and guidance to our employees and associates to ensure that our work and the mission of the corporation is pursued in an ethical and legally appropriate manner
- The program includes provisions for auditing, education, investigations of possible program violations, and voluntary repayments of any identified overpayments



# Key Compliance Plan Documents

- The “Code of Conduct”
- Compliance Policies and Procedures
- Accessible on the WVUPC website at [www.wvupc.org/compliance](http://www.wvupc.org/compliance)



# Compliance Plan Provides



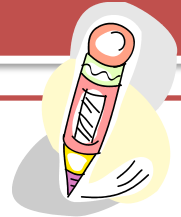
- Disciplinary sanctions apply for failure to abide by the Compliance Program requirements and/or the “Code of Conduct”
- Our compliance plan includes a “disclosure program” for reporting compliance concerns or issues
- There will be no retaliation/retribution for good faith reporting of compliance concerns

# Now, let's discuss Chart Documentation



**Laura Sullivan, CPC**  
Coordinator, Corporate Compliance  
Auditing & Education

# Why Good Documentation Matters?



- Provide specific and descriptive documentation
- Thorough documentation facilitates the rendition of high quality patient care for payors, the medical record is also used to provide documentation of the site of service, the medical necessity of the service, and that the service documented was the service billed and paid for.
- An appropriately documented medical record can reduce many of the “hassles” associated with claims processing and, if necessary, serve as a legal document to verify the care provided
- Good documentation is the key to correct coding of E/M services

# General Documentation Principles for All Types of Services

- The medical record should be complete and legible
- The documentation of each encounter should include:
  - The reason for the encounter and relevant history, physical exam findings and prior diagnostic test results
  - An assessment, clinical impression or diagnosis
  - A plan for care
  - The date and legible signature of the physician
- If not documented, the rationale for ordering diagnostic or other services should be easily inferred

# Chief Complaint

Each note must have a Chief Complaint (CC)

Ask yourself “**WHY** am I seeing this patient?”

*unacceptable*

CC: “no problems or complaints”

*acceptable but not ideal*

CC: “no new complaints” no further complaints”



# CC: Examples



## Office Examples

CC: Annual physical

CC: Pap & Pelvic

CC: follow up for PNA

CC: HTN & DM

## Hospital Examples

CC: No changes still SOB

CC: Pt has no complaints  
still following BP....

CC: Sugar still elevated....

*The following was an actual inpatient chief complaint*

*CC: No further episodes of breathing*

# Documentation Tips



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# History of Present Illness (HPI)

Document at least 4 of the following

Location

Quality

Severity

Duration

Timing



Modifying factors

Associated signs or symptoms

Context

# Past, Family & Social History (PFSH)

One element of each should be noted:

## Example 1:

Past: No surgeries

Family: mother has DMII

Social: Married no children



## Example 2:

PFSH: Patient poor historian,  
no family present to assist

## Example 3:

Past: Gallbladder removed 2008

Family: no known problems

Social: Non Smoker

## Example 4:

PFSH: Patient intubated and unresponsive  
unable to obtain

Non-contributory is **unacceptable** for any PFSH  
components

# Review of Systems (ROS)

ROS is a review of SYMPTOMS not illnesses or conditions.

HTN or DMII are not symptoms

Constipation, headaches, sweating, difficulty sleeping, short of breath, arm pain, swelling in toe are just a few examples of an ROS



# Review of Systems

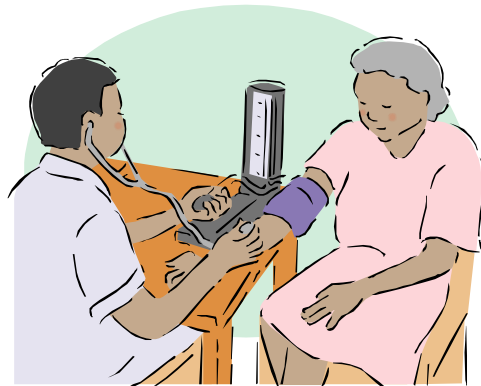
- Constitutional
- Eyes
- Ears, nose, mouth, throat
- Cardiovascular
- Respiratory
- GI
- GU
- Musculoskeletal
- Integumentary
- Neurological
- Psychological
- Endocrine
- Hem/Lymph
- Allergy/Immuno



List at least 2 positives and then you can state "all other systems negative"

# Examination Areas

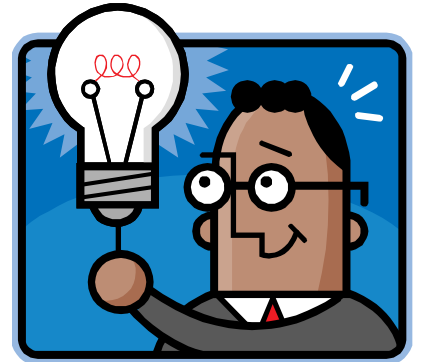
- Constitutional (vitals etc)
- Eyes
- Ears, nose, throat, mouth
- CV
- Resp
- GI
- GU
- Musculoskeletal
- Skin
- Neurological
- Psychological
- Hem/lymph/Immuno



Must document at least 8 areas for a complete exam

# Assessment & Plan

1. Documentation should include the condition or symptoms being treated
2. Labs & X-rays reviewed
3. Tests ordered
4. Consulting physicians requested
5. Medications ordered or prescribed
6. Risks and management options
7. Reasons for all of the above



# Procedures and Surgery

- Resident's should indicate the teaching physicians presence and participation in the procedure or surgery.

Note examples:

“Dr. X was present during the entire procedure”

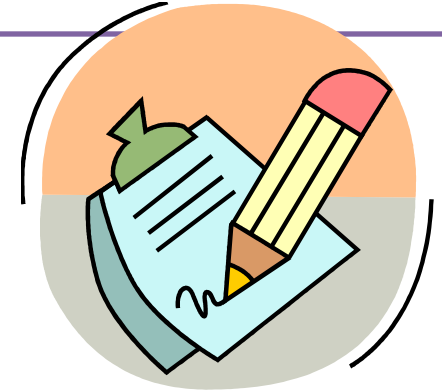
“Dr. X was present during the key and critical portion of the surgery”

\*\*only if the attending was present\*\*



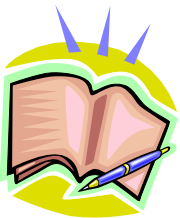
# Signature

- Sign each note legibly (no initials)
- Add pager number to signature
- Date each note clearly (time as necessary)
- Be proud of your degree and **add** MD or DO to your signature.
- You may have a stamp (*not a signature stamp*) with your **printed name** and pager number



# General Documentation Principles for All Types of Services

- Past and present diagnoses should be accessible to the treating and/or consulting provider
- Appropriate health risk factors should be identified
- The patient's progress, response to and changes in treatment and revisions in the diagnosis should be documented
- The CPT and ICD-9-CM codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record





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