A guide to improving clinical documentation in a changing health environment

4th edition

Deborah J. Grider
Ancillary content for *Medical Record Auditor*, Fourth Edition, is available for download from the following URL:

www.ama-assn.org/go/op301014mra4

The ancillary content includes:

**Audit Tools**
1. Detailed Review Analysis
2. Summary Report
3. E/M Audit Form, Tool #1
4. E/M audit Form, Tool #2
5. E/M Worksheet
6. OB/GYN Worksheet
7. Surgery Audit Tool
8. Surgery Summary Report
9. Surgery Detailed Analysis
10. Orthopedic Audit Worksheet
11. General Multi-system Audit Worksheet
12. Pulmonary Audit Worksheet
13. Radiology Audit Worksheet
14. Radiology Detailed Analysis
15. Radiology Detailed Analysis Sample
16. Radiology Summary Report
17. Radiology Summary Report Sample
18. Surgical Chart Auditing Worksheet
19. Physical Therapy Audit Tool

**Audit Exercises:** Case Studies and Answer Keys
- Gastrointestinal—office
- Orthopedic—office
- Family Practice—office
- Primary Care—hospital
- General Surgery—office
- General Surgery—hospital
- Pulmonary—office
- Cardiology—hospital
- Hemophilia—office
- Surgery
- Radiology

**PowerPoint Presentations**
- Chapter 1
- Chapter 2
- Chapter 3
- Chapter 4
- Chapter 5
- Chapter 6
- Chapter 7
- Chapter 8
- Chapter 9
- Chapter 12
- Chapter 13

**Chapter Exercise Answer Keys:** Test Your Knowledge & Check Point Exercises

**Sample Business Associate Agreement**

**CMS AB-01-44:** 1995 Documentation Guidelines for Evaluation and Management Services
Audit Prevention 85
Performing Internal Audits 88
The Corporate Integrity Agreement (CIA) 90
Test Your Knowledge 106
Resources 111

4 Documentation Basics 113
A Brief History of Medical Record Documentation 113
The Purpose of Documentation 115
The Medical Record as a Legal Document 115
Progress Notes 116
Soap Notes 122
Checkpoint Exercise 127
The Operative Report 127
Documentation Guidelines 136
How Documentation Affects the Coding Process 137
Test Your Knowledge 138

5 The Medical Record 141
Defining the Medical Record and the Role of the Medical Record Administrator 141
Medical Record Accountability and Privacy and Release of Medical Record Information 142
Components of the Medical Record 143
Advance Beneficiary Notices 167
Record Retention 172
Hipaa Privacy Regulations 176
Test Your Knowledge 186
Resources 188

6 Clinical Documentation Improvement 189
Documentation Standards 190
What is Clinical Documentation Improvement? 191
Importance of Clinical Documentation Improvement 192
Establishing a CDI Program in the Medical Office 193
The Certified Documentation Improvement Practitioner 203
Test Your Knowledge 204
Resources 206

7 Auditing Fundamentals 207
Top Coding and Documentation Errors 208
The Importance of Auditing and Analyzing Your Medical Records 209
Contents

9 Auditing the Office Medical Record  365
  Chart Auditing: Step by Step  365
  Beginning the Audit Process  368
  Test Your Knowledge  393

10 Evaluation and Management Audit Case Study Exercises in the Office Setting  407
  Primary Care  408
  Orthopedics  413
  Gastroenterology  417
  Pulmonology  420
  General Surgery  426
  Psychiatry  429
  Dermatology  431
  Oncology  435
  Cardiology  437

11 Evaluation and Management Audit Case Study Exercises in the Hospital Setting  441
  Primary Care  442
  Orthopedics  446
  Gastroenterology  449
  Pulmonology  453
  General Surgery  460
  Oncology  464
  Cardiology  468

12 The Surgical Medical Record  473
  Coding Based On the Standards of Surgical Practices  473
  Surgery Coding Rules  474
  CPT Global Surgery Package  474
  CMS Surgical Package  475
  National Correct Coding Initiative (NCCI)  484
  Separate Procedures  517
  Scope Procedures Versus Open Procedures  518
  Diagnostic Services Versus Therapeutic Services  519
  Add-On Codes  519
  Stand-Alone Codes and Indented Codes  521
<p>| Figure 3-1: | Comprehensive Error Rate Testing (CERT) Program | 65 |
| Figure 3-2: | RAC Regions | 75 |
| Figure 3-3: | Pre-Audit Checklist | 87 |
| Figure 3-4: | Sample Corporate Integrity Claims Review Report | 101 |
| Figure 4-1: | CMS Attestation Statement | 118 |
| Figure 4-2: | Lesion Excision Template | 121 |
| Figure 4-3: | Simple Operative Report | 129 |
| Figure 4-4: | Formal Operative Report | 129 |
| Figure 5-1: | Patient Registration Form | 146 |
| Figure 5-2: | Financial Responsibility/assignment of Benefits Form | 147 |
| Figure 5-3: | General Consent to Treat | 148 |
| Figure 5-4: | Medicare Lifetime Beneficiary Claim Authorization and Information Release | 149 |
| Figure 5-5: | Combination Consent for Treatment and Release of Information | 150 |
| Figure 5-6: | Patient History Form | 152 |
| Figure 5-7: | Problem List | 154 |
| Figure 5-8: | Medication sheet | 155 |
| Figure 5-9: | Form for Assessing Learning factors | 156 |
| Figure 5-10: | Adult Screening Form | 157 |
| Figure 5-11: | Pediatric Screening Form | 158 |
| Figure 5-12: | Consent Form | 159 |
| Figure 5-13: | Handwritten Patient Encounter | 160 |
| Figure 5-14: | Dictated Patient Encounter Report | 161 |
| Figure 5-15: | Form for Recording Patient Encounter (Adult) | 162 |
| Figure 5-16: | Laboratory Report | 163 |
| Figure 5-17: | Operative Report | 164 |
| Figure 5-18: | Patient Discharge Letter | 165 |
| Figure 5-19: | Immunization Form | 166 |
| Figure 5-20: | Medicare Waiver of Liability | 168 |
| Figure 5-21: | Record Retention Schedule | 174 |
| Figure 5-22: | Sample HIPAA Privacy Notice | 178 |
| Figure 5-23: | Sample Acknowledgment of Receipt of Notice of Privacy Practices | 184 |
| Figure 6-1: | Sample Query | 200 |
| Figure 7-1: | Patient Information Sheet | 217 |
| Figure 7-2: | Consent to Treat Form | 219 |
| Figure 7-3: | Medicare Advance Beneficiary Notice | 221 |
| Figure 7-4: | CMS-1500 Claim Form | 223 |</p>
<table>
<thead>
<tr>
<th>Table 2-1: Services Commonly Targeted for Postpayment Review</th>
<th>18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Table 2-2: Sample NCCI Column 1/Column 2 Edits for Code 27194 (Second Quarter 2014)</td>
<td>37</td>
</tr>
<tr>
<td>Table 3-1: FY 2013 Improper Payment Rate by Service Type</td>
<td>67</td>
</tr>
<tr>
<td>Table 3-2: 2013 Top Specific Service Overpayment Rates Billed to Part B</td>
<td>68</td>
</tr>
<tr>
<td>Table 3-3: National Improper Payments By Year and Error Category</td>
<td>69</td>
</tr>
<tr>
<td>Table 3-4: 2013 Projected Improper Payments by Type of Error and Clinical Setting (in Billions)</td>
<td>70</td>
</tr>
<tr>
<td>Table 6-1: Sample Medical Practice Baseline Analysis for E/M Services and Procedures</td>
<td>195</td>
</tr>
<tr>
<td>Table 6-2: Diagnosis Coding Baseline Analysis</td>
<td>196</td>
</tr>
<tr>
<td>Table 8-1: Complexity of Medical Decision Making</td>
<td>259</td>
</tr>
<tr>
<td>Table 8-2: Evaluation and Management Office Visit Selection Grid</td>
<td>264</td>
</tr>
<tr>
<td>Table 8-3: Evaluation and Management Hospital Visit Selection Grid</td>
<td>264</td>
</tr>
<tr>
<td>Table 8-4: CMS 1995 Documentation Guidelines for E/M Services</td>
<td>270</td>
</tr>
<tr>
<td>Table 8-5: CMS 1997 Documentation Guidelines for E/M Services</td>
<td>270</td>
</tr>
<tr>
<td>Table 8-6: Recognized Body Areas and Organ Systems According to CMS 1995 Documentation Guidelines</td>
<td>281</td>
</tr>
<tr>
<td>Table 8-7: CMS 1995 Documentation Guidelines for Examination</td>
<td>282</td>
</tr>
<tr>
<td>Table 8-8: CMS 1997 Documentation Guidelines for Examination</td>
<td>284</td>
</tr>
<tr>
<td>Table 8-9: 1997 General Multisystem Examination Table</td>
<td>285</td>
</tr>
<tr>
<td>Table 8-10: 1997 Cardiovascular Single Organ System Examination Table</td>
<td>288</td>
</tr>
<tr>
<td>Table 8-11: CMS 1995 Documentation Guidelines for Examination</td>
<td>291</td>
</tr>
<tr>
<td>Table 8-12: CMS 1997 Documentation Guidelines for Examination (General Multisystem)</td>
<td>291</td>
</tr>
<tr>
<td>Table 8-13: Table of Risk</td>
<td>294</td>
</tr>
<tr>
<td>Table 8-14: Medical Decision-Making Grid (Meet Two of Three Criteria)</td>
<td>295</td>
</tr>
<tr>
<td>Table 8-15: Number of Diagnoses or Management Options</td>
<td>298</td>
</tr>
<tr>
<td>Table 8-16: Amount and/or Complexity of Data Reviewed</td>
<td>298</td>
</tr>
<tr>
<td>Table 8-17: Results of Final Medical Decision Making</td>
<td>299</td>
</tr>
<tr>
<td>Table 8-18: Comparison of Consultation and Referral</td>
<td>316</td>
</tr>
<tr>
<td>Table 8-19: Office or Other Outpatient Consultations</td>
<td>318</td>
</tr>
<tr>
<td>Table 8-20: Inpatient Consultation Selection Grid</td>
<td>318</td>
</tr>
<tr>
<td>Table 8-21: E/M Initial Observation Selection Grid</td>
<td>332</td>
</tr>
<tr>
<td>Table 8-22: E/M Subsequent Observation Selection Grid</td>
<td>332</td>
</tr>
<tr>
<td>Table 8-23: Inpatient Discharge Services</td>
<td>334</td>
</tr>
<tr>
<td>Table 8-24: Nursing Facility Discharge Services</td>
<td>335</td>
</tr>
<tr>
<td>Table 8-25: E/M Observation Care Selection Grid</td>
<td>336</td>
</tr>
</tbody>
</table>
Table 8-26: CPT Code Threshold Times 337
Table 8-27: Care Plan Oversight 340
Table 8-28: Complex Chronic Care Management Time 354
Table 9-1: Categories for Determining Type of History 372
Table 9-2: 1995 vs 1997 Examination Documentation Guidelines 373
Table 9-3: Body Areas and Organ Systems 374
Table 9-4: Table of Risk 379
Table 9-5: Medical Decision-Making Requirements 380
Table 9-6: Medical Decision-Making Grid for Number of Management Options 381
Table 9-7: Medical Decision-Making Grid for Amount and/or Complexity of Data Reviewed 381
Table 12-1: Medicare Reimbursement Tool 484
Table 12-2: List of Codes Bundled into Code 28175 485
Table 12-3: Column 1/Column 2 Edits: List of Codes Bundled into Code 61304 497
Table 12-4: List of Codes Bundled into Code 61720 506
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Documentation was traditionally generated and used only by the provider or physician as a source of information for patient care. The information was kept in the patient's medical record or chart, or on a card kept in a file. Until about 30 years ago, the only people who had access to the patient's medical record were the physician and his or her staff. Insurance carriers did not require the physician to submit documentation to support charges submitted. Chances of the medical record becoming a legal document in a malpractice case were minimal. Standards for recording the information in the patient's medical record did not exist. Physicians were not required to submit charges based on documentation.

The role of documentation today has changed dramatically. There are many reasons for the change in requirements. Medical malpractice claims have risen dramatically, the medical record serves as a legal document, the medical record serves as information about the patient's care, insurance carriers require documentation to support the level of service billed to them, and the medical record serves as evidence in defense of insurance fraud or malpractice. In addition with the implementation of the electronic medical record, documentation is even more important to support the care provided to the patient.

PURPOSE OF ANALYZING THE MEDICAL RECORD

Given the increased scrutiny of the medical record in the physician's practice, developing standards for analyzing the medical record may help the provider maintain compliance with the government, insurance carriers, and other agencies that review medical records. Accrediting bodies responsible for rating a health care organization use contents of the medical record to evaluate services to the patient.

To effectively analyze the medical record, the health care professional should begin by learning the basics of the medical record, how to review the medical record for correct coding, and how to build auditing skills with continuous practice. This text will discuss the medical record structure, coding guidelines, documentation and its importance, review guidelines we use today, and give explanations and examples with tips to help along the way. In addition, chart-auditing fundamentals along with case studies are included in this publication.

Mastering the process of medical record analysis is a building-block process. It is building from the basics to the most complex medical record documentation. Basic rules, which remain constant and expand to include evaluation and management services through complex surgical procedures, will be reviewed. Tools that are essential to the analysis of the medical record will be described, along with detailed instructions on how to use them.
LEARNING OBJECTIVES

Those completing this text will be able to understand how the medical record is structured, documentation and coding guidelines, the components of the medical record, a working knowledge of the Evaluation and Management Guidelines, understand Regulatory Information and Guidelines and how to review medical record documentation to determine the service provided. Upon completion of this text, the health care professional not only will be able to review and analyze the medical record, but will gain valuable information regarding what to do after the analysis is completed, how to provide education to other health care professionals within an organization, and how to formulate a plan for improving coding and documentation.

Auditing the medical record is not an exact science. There are many variables as well as differences with insurance carrier policy. This book is a tool to help the reader understand the principles of medical record documentation and chart auditing. With increased carrier scrutiny, it is imperative that professionals in the coding, billing, reimbursement, consulting, and health care professions at large have a good understanding of insurance carrier expectations.

HOW TO USE THIS BOOK

This book introduces the reader to principles of medical record documentation, and how to conduct a medical record chart review in the physician’s or outpatient office. The information provided herein will prepare the reader to accomplish the following objectives:

- Understand the medical record
- Review documentation basics and formatting of chart notes
- Review documentation guidelines and elements required for each level of service
- Understand the medical record review process (auditing)
- Properly audit the medical record using tools provided
- Analyze and report results of the medical chart review (audit)
- Develop a mechanism for reporting and education
- Understand the importance of developing a performance improvement plan
- Review how a Clinical documentation improvement program can benefit the medical practice.
- Comprehend the changing political environment affecting healthcare
- Prepare for credentialing examinations

Medical Record Auditor contains learning objectives at the beginning of each chapter that will offer an overview of chapter content and help measure progress. These objectives may also assist the instructor using this text in
preparing lecture material. Medical chart review and coding tips are provided to help the reader understand the topic discussed. Key terms are found in the Glossary. Application and checkpoint exercises are given in the chapters to allow the reader to learn each chapter, one at a time, building on the medical record analysis process. These exercises are presented in a variety of formats, including true/false, multiple choice, fill-in-the-blank, and short answer. Audit exercises by practice specialty are found in the ancillary content for added practice in skill development. The audit exercises will challenge the reader to analyze case histories and prepare a detailed analysis and summary report. These exercises may be used to analyze the reader's knowledge of the audit process or can be used as a final examination for instructors using this text in the classroom.

This book is designed to be used by community colleges, career colleges, and vocational school programs for training coders, medical insurance specialists, and other health care providers. It may also be used as an independent study training tool for physicians, coders, consultants, independent billing or reimbursement personnel, and any others in the health care field who want to learn additional skills.
During my thirty-two years in the health care field, I have educated hundreds of students, physicians, colleagues, and instructors who have indirectly contributed to my career success. I wish to express my thanks to all of them. They all have truly enriched my life. I wish to particularly thank all the many students that I have mentored and who have given me good ideas, comments and remarks which I hope have made this Fourth edition a better teaching tool. This book may also be used to prepare for the American Academy of Professional Coders CPMA examination. I want to thank all my colleagues who worked on this examination with me who gave me great insight into enriching this book.

I am also grateful to the wonderful AMA editorial and production staff who helped make this book a reality.

But students, colleagues, production staff, and editors working alone do not make the project a book; there are others to whom I am deeply indebted. I wish to thank my family, especially my husband Jerry, who offered support, encouragement, and motivation throughout the preparation of this book along with his understanding of the priority this project took on my commitments to allow me the opportunity to do what I most love.

Lastly, I wish to thank the reviewers, Kelly Merry CPC, CMCO, ICD10CT-CM and Melody Jajou CPC, who offered insightful comments and suggestions.

Deborah J. Grider
THE ROLE OF THE MEDICAL RECORD AUDITOR

LEARNING OBJECTIVES

■ Review the reasons for and the benefits of auditing medical records
■ Understand the role of the medical record auditor
■ Review the qualifications and skills required for the medical record auditor
■ Understand the importance of certification
■ Test your knowledge

Coding and compliance have been under a magnifying glass since the passage of the Health Insurance Portability and Accountability Act (HIPAA) and the Federal False Claims Act (FCA) in the early 1990s, making medical record auditing a necessity. With recovery audit contractors (RACs), Medicaid integrity contractors (MICs), the government, and commercial payers all increasing their scrutiny of providers’ documentation and coding, it is more important than ever for the medical practice to implement functional compliance plans, ongoing monitoring, and auditing practices to assure accurate and timely coding, documentation, and reimbursement. And in an environment of constant reimbursement rule changes and an ever-expanding array of medical codes, access to knowledgeable, experienced medical coding professionals are critical for the sustainability and growth of any health care organization.

THE PURPOSE OF MEDICAL RECORD AUDITING

Medical record auditing entails conducting internal or external reviews of documentation coding accuracy, policies, and procedures to ensure that practitioners are compliant and meet all coding and billing regulations of the payer when submitting a claim. Audits may be conducted internally by the practice or by an independent consultant or coding auditor working outside of the medical practice. The internal audit is conducted to find and correct inconsistencies with documentation and coding before an insurance carrier uncovers the errors. Such review is an important element of compliance in the medical practice.
CLINICAL DOCUMENTATION IMPROVEMENT

LEARNING OBJECTIVES

- Understand the importance of clinical documentation improvement
- Learn how to establish a clinical documentation improvement program in the medical office
- Understand how clinical documentation improvement can help improve documentation and coding
- Review the qualifications and role of the Certified Documentation Improvement Practitioner

The patient medical record tells the story of the patient encounter from beginning to end. Clinical documentation improvement (CDI) goes beyond the good compliance practice of auditing and monitoring by working toward improving documentation and coding on an ongoing basis. Most CDI programs are focused on hospital documentation and coding, but in reality, documentation begins and ends with the practitioners (physicians and non-physicians). A CDI program can bridge the gap between the clinicians and coding and billing systems by increasing and capturing the appropriate reimbursement for services provided. A CDI program can also help to accurately reflect the severity of illness, complexity of care, and resources utilized in the medical practice.

The need for accurate clinical documentation is more important not only for payment but also to validate medical necessity and support quality of care. The message to all practitioners is that CDI is a quality initiative. In medical school, physicians are taught how to document from the clinical perspective, but in most cases, they are not taught how to document in order to assign the most accurate procedure and diagnosis codes.

While the electronic health record (EHR) has improved the legibility and timeliness of documentation, documentation has become more “cloned” than ever. In an EHR, all of the documentation has started to look the same for every encounter, which can invalidate the encounter during a carrier audit. Since 1995 we have been teaching physicians how to document their
The diagnosis is documented in the assessment but does not meet the documentation guidelines for reporting the status of the condition.

- The level of service provided does not meet the CPT or CMS requirements for the level of service.
- Other services are reported but not documented.
- The documentation lacks detail to support the services billed (eg, modifier usage, lack of specificity, lack of clarity).
- The documentation is not signed and/or dated.

Lack of accurate and complete documentation can result in the use of non-specific and general codes, which can impact data integrity, reimbursement, and present potential compliance risks.

When developing multiple queries, analyze common problem areas such as level 4 E/M services for a new patient (99204). The key component requirements for a level 4 E/M service are a comprehensive history with a comprehensive examination with moderate complexity decision making. Let’s say that you find a pattern in the practice of overutilizing this service about 30% of the time. Such a finding would substantiate developing a standard query for this billing practice. Review the sample query shown in Figure 6-1.

**Figure 6-1**

**Sample Query**

<table>
<thead>
<tr>
<th>Practitioner</th>
<th>David Smith, MD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Name</td>
<td>Areale Arcadia</td>
</tr>
<tr>
<td>Medical Record Number</td>
<td>1247890</td>
</tr>
<tr>
<td>Date of Service</td>
<td>05/28/20xx</td>
</tr>
<tr>
<td>Date of Query</td>
<td>05/30/20xx</td>
</tr>
<tr>
<td>Name of Person Initiating Query</td>
<td>Marlene Palmaner</td>
</tr>
<tr>
<td>Query</td>
<td>A level four (99204) new patient visit was reported. In the assessment and plan, can you provide the type of the diabetes, and status of the patients CKD to support the medical necessity for this service?</td>
</tr>
</tbody>
</table>

The purpose of the query is not to challenge the practitioner’s clinical judgment. Practitioners often make clinical diagnoses or management decisions based on their knowledge and expertise in their specialties even if test results are negative. This illustrates a good reason why a physician champion can be of great benefit. In these situations, the patient encounter should be given to the physician champion to make the determination as to whether a query should be sent to clarify the coding, or if it is supported by the documentation.
It is recommended that queries be electronic and written with precise language. The query should identify the clinical indications from the medical record and ask the provider to make a clinical interpretation of these facts based on his or her professional judgment of the patient encounter. Queries that appear to lead the provider to document a particular response could result in allegations of inappropriate coding. The query format should not lead the practitioner to make an assumption. Queries should be developed to ask questions, not to ask the practitioner to document something more to get paid.

Verbal queries have become more common as a component of the concurrent query process. The desired result of a verbal query is documentation by the provider that supports the coding of a condition, diagnosis, or procedure. Again, the protocol should be incorporated in the CDI policy.

### Query Do's and Don'ts

<table>
<thead>
<tr>
<th>DO:</th>
<th>DO NOT:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ask the provider to clarify either the procedure or diagnosis code</td>
<td>Ask leading questions</td>
</tr>
<tr>
<td>Ask the provider to amend the note if he or she omitted the information in error</td>
<td>Tell the practitioner what needs to be documented to get paid for the service</td>
</tr>
<tr>
<td>Provide your queries in either a question or multiple choice format</td>
<td>Send queries on post-it notes, scrap paper, or handwrite queries</td>
</tr>
<tr>
<td>Use electronic tools if possible</td>
<td>Challenge the practitioner’s clinical judgment</td>
</tr>
<tr>
<td>Develop a template for sending queries</td>
<td></td>
</tr>
</tbody>
</table>

Queries should be reviewed periodically to ensure that any templates built meet coding standards based on guidelines, regulations, and coding rules. You should also review queries to ensure the language is not leading or inappropriate and to make sure the query is necessary. Lastly, monitor the number of queries per month sent to each practitioner. If you are seeing an unusual amount of queries being sent, the practitioner might need some individual assistance or help with documentation and/or coding.

Again, keep in mind that part of the query process is to continuously audit and monitor the practitioner’s documentation to ensure accurate and complete documentation in the medical record. If you are auditing and monitoring in the EHR, make sure you look for “cloned” documentation, which has become endemic in EHRs. The electronic macros practitioners use (sometimes called “smart text”) can pull in old and outdated information, or can lead to false or fraudulent documentation. Improvement in documentation should be realized over time with the reduction in the number of queries. Education and training is vital to the CDI program as well as compliance in the medical practice.

**Auditing Tip**

When auditing, don’t forget to focus on problematic diagnoses.
**TABLE 8-29**

**Complex Chronic Care Management Time**

<table>
<thead>
<tr>
<th>Total Duration of Staff Care Management Services</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 60 minutes</td>
<td>Not reported separately</td>
</tr>
<tr>
<td>60-89 minutes (1 hour–1hr. 29 min)</td>
<td>99487</td>
</tr>
<tr>
<td>90-119 minutes (1hr. 30 min.–1hr. 59 min)</td>
<td>99487 and 99489 x 1</td>
</tr>
<tr>
<td>120 minutes or more (2 hours or more)</td>
<td>99487 and 99489 x 2 and 99489 for each additional 30 minutes</td>
</tr>
</tbody>
</table>

The care management practice/office must have the following capabilities:

- Provide 24/7 access to physicians or other qualified health care professionals
- Identify patients who require chronic complex care coordination services with a standardized method
- Have an internal care coordination process where patients can be identified as meeting the requirements for services and receive the services in a timely manner
- Use a form, format, or process in the paper or electronic health record (template) that is standardized
- Able to engage and educate patients and caregivers and coordinate care among all service professionals

**AUDITING TIP**

When auditing these services it is important to reference what other services or procedures are included in care management services.

If care management resumes after the patient is discharged from the hospital during a new month, either start a new period or report Transitional Care Management Services (99495 and 99496).

If care coordination resumes after the patient is discharged from the hospital during the same month, continue the reporting period or report Transitional Care Management Services (99495 and 99496). Codes 99487 and 99489 may not be reported if reporting codes 99495 or 99496 for Transitional Care Management Services within 30 days of reporting the Transitional Care Management Services for a patient who has any post-discharge complex chronic care coordination need within 30 days of discharge.