EVMS MEDICAL GROUP

Compliance Newsletter

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Compliance Hotline

Type:

http://157.21.29.163/Compliance/

and click on Hotline.

EVMS Medical Group Compliance concerns may also be sent to the EVMS Medical Group Compliance Office via phone, mail or e-mail.

Medical Records Survey & Fee Changes

In late July the Compliance Office conducted an informal survey regarding outside requests for medical records. The survey gathered information about the number and type of staff processing these requests, the number, frequency and volume of the requests themselves, the agencies or organizations requesting information as well as whether or not each division is currently charging for records.

Responses were received from every division and location and an array of different roles or job descriptions complete these requests across the practice plan to include Health Information Services Clerks, Medical Records Clerks, Health Information Technicians, RNs, Administrative Secretaries, Administrative Assistants, Medical Receptionists, Office Managers, Referral Coordinators, and LPN Supervisors. Out of 15 responses 5 divisions have only 1 person responsible for requests while 7 divisions have 2 individuals and the final 3 have 3 or more responsible or cross-trained. Survey responses about the type, frequency and volume of requests were as follows:

On average, how many requests for medical records do you receive weekly?	
Answer	**Number**
Less than 5	2
5-10	1
10 -15	6
20 or More	7
Total	16

Contact Us

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Phone 451-6200

Link to Policies & Forms:

http://www.evms.edu/patient_care/compliance_program/

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Compliance "Listserv"

Send an email to browerl@evms.edu to request to be added to the EVMS Medical Group Compliance "Listserv". Once you are subscribed, you will receive newsletters, information and training opportunity announcements directly.

Where do the majority of your requests for medical records come from?	
Answer	**Number**
Patients	7
Attorneys/Subpoenas	5
Government Agencies	3
Other	8
Total	23

On average, what is the size of requests for medical records received?	
Answer	**Number**
25 Pages or Less	6
25 to 100 Pages	10
More than 100 Pages	0
Electronic	0
Total	16

Are you currently charging for records provided to patients or attorneys?	
Answer	**Number**
Currently Charging Patients	1
Currently Charging Attorneys	2
Currently Charging Both Patients and Attorneys	5
Not Charging for Records	7
Total	15

The wide variety of roles and number of individuals who are completing medical record requests make ensuring that adequate training and resources are received even more important. Based on the information gathered our practices are receiving a high volume of requests daily however the number of pages or amount of information for each request is not large. This data is shared for perspective and informational purposes as we prepare to put a new Fee policy into effect that will likely make significant changes to the way we charge for medical records at present. If your division is still charging for records by page please cease to do so until the new policy has been released. For more information please contact the Compliance Office.

HCC Coding: M.E.A.T.

The Official ICD-10 Coding Guidelines state that a condition must exist at the time of the encounter and affect patient care or management and be documented in order to be coded as a

diagnosis. All conditions affecting the treatment or management of the patient's health should be documented at least once a year, as applicable to care provided, to accurately describe the true complexity and severity of the patient's conditions. If the diagnosis coding on the claim is not accurate or complete, the claim may indicate that the provider did much less medical decision-making, evaluation, and management than was actually performed. Documentation for a valid reportable diagnosis must clearly indicate evidence of M.E.A.T., for each diagnosis. M.E.A.T. is an acronym used to describe four factors that help providers to establish the presence of a diagnosis during an encounter in proper documentation:

M-monitored: signs, symptoms, disease progression, disease regression

E-evaluated: test results, medication effectiveness, response to treatment

A-assessed/addressed: ordering tests, discussion, review records, counseling

T-treated: medications, therapies, other modalities

Documentation to support or validate risk adjustment conditions may be found anywhere in the note for the face-to-face encounter. It is important to ensure that the note accurately reflects all chronic conditions that affect the health and care of the patient. Each encounter must be unique and reflect only that visit as it occurred. Chronic conditions require long-term attention and management, and familiarity with the patient. Insufficient documentation influences the assignment of diagnosis codes and directly affects the patient's risk score.

Documentation should be concise, include the reason for the face-to-face visit, and support the need for the patient to be monitored, evaluated, assessed, and/or treated for the conditions listed through clinical rationale and/or plan of care described in clear (legible) notes. Each page of progress notes should be properly authenticated and include the patient's name and the date.

Providers should document each clinical diagnosis to the highest degree of specificity per encounter, including all complications and/or manifestations, including clear links to causal conditions. Only confirmed conditions should be documented—no rule-out conditions or abnormal findings without clinical significance. All know conditions, including chronic conditions and test or report results, and document the status of any changes to the condition, using terminology such as decreased, increased, worsening, improving, or unchanged. Documentation should include supporting evidence of the results or plan of care. Remember, the road to success starts and ends with M.E.A.T.

Example of MEAT documentation:

CKD stage 3: Patient presents with diabetes and Chronic Kidney Disease (stage 3).

(M) Last GFR 40, (**E)** decreased from 45. Hgb A1C controlled. Compliant with ACE. No peripheral edema. (**A/A)** Plan BMP today. (**T)** Advised to avoid NSAIDs. Provided information on kidney disease.

e-PHI Security Tip

When searching for a patient record in Allscripts best practice is to use the patient's MRN or if not available, to match all other demographic points to select the correct patient. When conducting EHR user audits the Compliance Office often notes that staff are accessing multiple records for patients with the same or similar names to find the correct patient. Not only is this not time effective it can also lead to impermissible access and disclosures of PHI. As a reminder, all access to patient information should be driven by a business, work-related purpose.

Lunch Discussion Session October

Topic: ICD-10 Updates & HCC Coding

Who Should Attend: Those involved in the coding/billing process as well as those responsible for assigning codes to include providers and as always, managers and supervisors in these areas.

Date and Location:
Thursday, October 24th, 12-1:00 pm in HH 223

Please RSVP to Laura Brower at browerl@evms.edu or 451-6202 and feel free to bring your lunch!