Billing Procedures

Faculty Billing and Documentation Guidelines

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INTRODUCTION

The purpose of the guidelines is to provide CU Medicine members with information concerning the documentation and billing of professional fees for services furnished to patients by faculty members of the University of Colorado School of Medicine (SOM).

The documentation guidelines are consistent with the CU Medicine Compliance Plan (see Appendix A). CU Medicine is committed to full compliance with all regulatory requirements concerning documentation and billing. The basis for CU Medicine's guidelines is the Federal Register, Volume 60, No. 236 effective 7/1/96 as operationalized in the Medicare Carriers Manual, Section 15016 (Appendix D revised 11/2002). The guidelines also reflect Colorado Department of Social Services Staff Manual Volume VIII; requirements for documentation and billing of professional fees. The guidelines may be revised as necessary pending revisions in insurance or governmental regulations. CU Medicine will provide updates to these guidelines on a timely basis.
Any requests received from Federal, State or Commercial carriers must be sent to the Director of the Audit, Compliance & Education Department who will respond to the carriers.

The guidelines contain basic information on requirements for billing the professional services of a teaching physician and other approved providers. The provider may refer to the most current edition of the Physicians' Current Procedural Terminology (CPT) manual for specific, detailed information on procedural coding. You may check with the Fee Coordination department for the most current edition of the CPT manual.

It is the individual faculty member's responsibility to have all of the required documentation in the patient's medical record before they submit a charge. Please remember that payers may hold individual providers, as well as billing organizations, responsible for claims submitted for clinical providers.

New providers are required to sign a Faculty Member Attestation and Receipt of CU Medicine Billing and Documentation Guidelines document. The provider attests to the electronic billing process whereby a provider will receive a report on regular intervals detailing all of the encounters submitted to a third-party payer, including Medicare and Medicaid, on behalf of the provider and the provider will be held accountable for the charge and the documentation in support of their billing. An annual reminder communication will occur via email.

Providers may not copy patient medical records or lists for any non healthcare deliveries.

If providers have any questions concerning medical record documentation and/or CU Medicine coding and billing policies, please contact the CU Medicine Audit, Compliance & Educaiton Department or the CU Medicine Coding Services department.

GENERAL PRINCIPLES OF MEDICAL RECORD DOCUMENTATION

Medical record documentation is required to record pertinent facts, findings, and observations about an individual's health history, examinations, tests, treatments, and outcomes. The medical record chronologically documents the care of the patient and is an important element contributing to quality of care. The medical record serves the need for communication and continuity of care among physicians and other health care providers. An appropriately documented medical record may also serve as a legal document to verify that care was provided. Documentation is also needed for accurate and timely claims review.

The principles of documentation are applicable to all types of medical and surgical services in all settings. The medical record should be complete and legible. The documentation of each patient encounter should include:

- the reason for the encounter and relevant history, physical findings and prior diagnostic test results;
- assessment, clinical impression or diagnosis;
- plan for care; and
- **date and legible identity of the provider**.[1]
  Medicare Program Integrity Manual CMS Pub. 100-08, Chapter 3, Sec. 3.4.1.1 B and our Medicare intermediary Trailblazer's Healthcare requires that documentation must be signed and dated by the provider. Also the Colorado Medicaid Carrier (ACS), requires that the providers to sign and date their documentation.

If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred. Past and present diagnoses should be accessible to the treating and/or consulting physician. The patient's progress, response to treatment and the revision of diagnosis should be documented.[2]
The services rendered by the provider are reported to third party payers by using CPT codes. The diagnosis of the patient must also be reported by using the International Classification of Diseases codes (current version ICD-9). These CPT and diagnostic codes must be supported by documentation in the medical record.

Documentation of services rendered by CU Medicine providers must be documented in the medical record in accordance with UPI's documentation guideline approved by the CU Medicine Board of Directors on 9/16/03 (Appendix I). The guideline simply stated, requires all CU Medicine members to either dictate, type, hand-write or electronically document any/all patient care services within 24 hours.[3]
When utilizing an electronic signature for medical record documentation, it must be done in a controlled, secured and password protected environment.

Fee Coordinators receive and review Open Encounter reports weekly. The fee coordinator will send providers a weekly reminder/notification e-mail if the encounter(s) contain missing documentation which needs to be completed and/or a charge filed, to ensure timely filing of the claim. As a reminder, if the teaching physician participates in the care of the patient with a resident/fellow who documents the service, the teaching physician must also create a progress note to establish physical presence (tie in statement). If these encounters are not completed and/or closed within forty-five (45) days, they will be closed administratively with a $0 charge.

[1] Medicare Program Integrity Manual CMS Pub. 100-08, Chapter 3, Sec. 3.4.1.B
http://www.cms.gov/manuals/downloads/pim83c03.pdf

[2] Documentation Guidelines for Evaluation and Management Services (AMA/CMS)
http://www.cms.gov/MLNProducts/downloads/eval_mgmt_serv_guide-ICN006764.pdf

[3] CU Medicine Guideline on Timely Documentation – Appendix I

DOCUMENTATION STANDARDS OVERVIEW

The guidelines for documentation in the medical record are identical whether inpatient or outpatient care is furnished. The medical record **must** be documented clearly to show the teaching physician's physical presence at the time the service was provided. The signed documentation should support the level of service rendered by the teaching physician. The teaching physician may refer to notes written by interns, residents, or fellows. If the teaching physician refers to a note documented by an intern, resident, or fellow the combination of both the teaching physician's note and the resident's note may be used to determine the level of service. Documentation by the teaching physician such as "Seen, and agree"[4] followed by a signature is **not acceptable documentation** to substantiate any level of service.

A student is never considered to be an intern or a resident. A student means an individual who participates in an accredited educational program (e.g., medical school) that is not an approved GME program. From a billing standard, documentation provided by a student (medical, nurse practitioner, physician assistant, nurse midwifery) may be used to support **only** the review of systems (ROS) and the past, family and social history (PFSH) elements of an Evaluation and Management service (E&M). The teaching physician or resident may not include a student's documentation of history present illness, physical exam findings or medical decision-making in his/her personal note. If the medical student documents an E&M service, the teaching physician or resident must verify and re-document the chief complaint, history of present illness as well as perform and re-document the physical exam and medical decision making activities of the service.[4]

- Teaching physicians or residents may **NOT** tie to student (medical or mid-level) documentation to support billing. The **ROS** and **PFSH** are the **ONLY** areas that may be referenced.
- Nurse Practitioners and Physician Assistants may **NOT** tie to resident/intern or student (medical or mid-level) documentation to support billing. The **ROS** and **PFSH** are the **ONLY** areas that may be referenced.

There are three circumstances that payments will be made to teaching physicians when the services are provided in a teaching setting [4]:

- The services are personally furnished by a physician who is not a resident;
- A teaching physician was physically present during the critical or key portions of the service that a resident performs;
- A teaching physician provides care under the conditions of the primary care exception clinics.

The following paragraphs will address the teaching physician's functions and documentation requirements in order to bill for services furnished in an academic setting.

[4] CMS Carriers Manual Part 3- Claims Process- 11/22/2002
http://www.cms.gov/Transmittals/Downloads/R1780B3.pdf