Northwest Ohio Osteopathic Association November 13, 2020

- Protecting your medical license and your career by avoiding recordkeeping pitfalls, controlled substance prescribing landmines, and the dangers of telemedicine

- John R. Irwin, J.D., M.D.

3:20:56

Truth vs. Proof

- Trial Lawyer's Creed:
- "I don't care about what's true."
- "I only care about what I can prove."

Today's Key Points

- Know your duty to know the law.
- Ignorance is no defense.
- But, it is impossible to know the law.
- Too large, too many layers.
- Changes every day.
- Know What the Profession Expects
- Know what State Law Wants
- Know What Federal Law Demands

Suggestions:

- Monthly appointments.
- Be able to prove an effort.
- Never guess or open an unprepped mouth.

- Now let me prove why.

It's True!

Controlled Substances Landmines

- Do they use drones for surveillance?
- Not quite yet
- But they come wired and plant video cameras
- Landmines:
  - Shooting from the hip
  - Not knowing the rules

Irwin's Third Law

- "She's not a patient"
- She was an employee
- "No more than four prescriptions"
- 17 prescriptions
- DEA surrender
- Med Board suspension

The Third Law Again

- “A couple of prescriptions”
- Actually, wrote several
- Later in the interview
- “Sorry, I wrote several, I apologize”
- Convicted 2nd degree misdemeanor
- Obstruction of official business
- Med Board hearing, etc.
- Reprimand, fine, but no probation

Keeping Records Correctly

- How often have we been told?
- Document, document, document.
- If not documented, not done.
- But is that really true?
- So, what and why, do we really have to document in our medical records?
- And is your chart going to be your best friend or your worst enemy?

What to Document?

- Medically, document information that is clinically relevant;
- In other words, information that will affect the patient's management.
- We usually know this.
- But, legally, it's another matter.
- Legally, document information that the law demands.
- We often don't know this.

Know your duties as a Physician

- We have a duty to know what we are doing
- Ignorance is no defense to either bad medicine or bad law
- The government's job is not to teach us how to practice good medicine, we're supposed to have learned that.
- The government's job is not to teach us how to practice legal medicine, we're obligated to know that.
- Make an appointment to know the law

Knowing the State Law (For illustration Purposes Only)

- Ohio Medical Board Statutes: 52,290 words
- Ohio Medical Board Rules: 34 Sections
- Ohio Controlled Substances Rule
- OAC 4731-11: 11,297 words (just one section)

- Documentation Requirements, extensive

Example:
Ohio Controlled Substances Rule 4731-11

- **4731-11-02 General provisions.**
- (A) A physician shall not utilize a controlled substance other than in accordance with all of the provisions of this chapter of the Administrative Code.
-
- (B) A physician shall not utilize a controlled substance without taking into account the drug's potential for abuse, the possibility the drug may lead to dependence, the possibility the patient will obtain the drug for a nontherapeutic use or to distribute to others, and the possibility of an illicit market for the drug.

Example:
Ohio Controlled Substances Rule 4731-11

- (C) A physician shall complete and maintain accurate medical records reflecting the physician's examination, evaluation, and treatment of all the physician's patients. Patient medical records shall accurately reflect the utilization of any controlled substances in the treatment of a patient and shall indicate the diagnosis and purpose for which the controlled substance is utilized, and any additional information upon which the diagnosis is based.
-
- (D) A physician shall obey all applicable provisions of sections 3719.06, 3719.07, 3719.08 and 3719.13 of the Revised Code and the rules promulgated thereunder, all prescription issuance rules adopted under Chapter 4729. of the Revised Code, and all applicable provisions of federal law governing the possession, distribution, or use of controlled substances.

Ohio Subacute and Chronic Pain Rule 4731-11-14

- Modified and Effective 11/1/2020

Example: Prescriptions

- Record details, i.e., amount, numbers, strength, dosage, schedule, etc., etc. in chart as well as on script.
- “Refill Rx” is inadequate
- Record ancillary information as required by your state, e.g., details of current status, progress, referrals, consults, plans, etc.

Ohio Controlled Substances Rule

- 11,297 words
- “Records” appears10 times
- “Report” appears 57 times
- “Document” appears 32 times

Punishment

- (E) Violations of this rule:

- (1) A violation of any provision of this rule, as determined by the board, shall constitute any or all of the following: "failure to maintain minimal standards applicable to the selection or administration of drugs," as that clause is used in division (B)(2) of section 4731.22 of the Revised Code; and "a departure from, or the failure to conform to, minimal standards of care of similar physicians under the same or similar circumstances, whether or not actual injury to a patient is established," as that clause is used in division (B)(6) of section 4731.22 of the Revised Code.

- (2) A violation of paragraph (C) of this rule shall further constitute "selling, prescribing, giving away, or administering drugs for other than legal and legitimate therapeutic purposes," as that clause is used in division (B)(3) of section 4731.22 of the Revised Code.

Drug Trafficking?

- What's the difference between a Physician and a Dope Dealer?
- Legal non-compliance
- Ignorance of the law

The thin line between prescribing and trafficking

- *State v. Nucklos*, 2009-Ohio-792
- R.C. 2925.03(B)(1) provides that the criminal offense of trafficking in drugs under R.C. 2925.03(A)"does not apply" to a licensed health professional who complies with applicable statutory or regulatory requirements.
- And there are a lot of requirements
- And, how are you going to prove compliance?

Prescription Drug Monitoring Programs

- All states and D.C. have operational PDMPs that have the capacity to receive and distribute controlled substance prescription information to authorized users.
- Know your state requirements, they vary greatly.

Current Ohio PDMP (OARxRS)

- Ohio Administrative Code 4731-11-11(D) (OARRS), effective 12/31/15
- All "Reported drugs" i.e., Schedule II-V
- Opiates and Benzo's, before first Rx.
- Others after 90 days
- Whenever any of red flags appear
- Mandatory records and management
- Opiates and Benzo's updates q. 90 days
- Others annually
- No OARRS required in hospital, hospice, Rx<7 days, surgery, cancer

Red Flags in Ohio

- OAC 4731-11-11(C)
- (3) A physician shall obtain and review an OARRS report when any of the following red flags pertain to the patient:
- (a) Selling prescription drugs;
- (b) Forging or altering a prescription;
- (c) Stealing or borrowing reported drugs;
- (d) Increasing the dosage of reported drugs in amounts that exceed the prescribed amount;
- (e) Suffering an overdose, intentional or unintentional;
- (f) Having a drug screen result that is inconsistent with the treatment plan or refusing to participate in a drug screen;

Red Flags, continued

- (g) Having been arrested, convicted, or received diversion or intervention in lieu of conviction for a drug related offense while under the physician's care;
- (h) Receiving reported drugs from multiple prescribers, without clinical basis;
- (i) Traveling with a group of other patients to the physician's office where all or most of the patients request controlled substance prescriptions;
- (j) Traveling an extended distance or from out of state to the physician's office;
- (k) Having a family member, friend, law enforcement officer, or health care professional express concern related to the patient's use of illegal or reported drugs;
- (l) A known history of chemical abuse or dependency

Red Flags, continued

- (m) Appearing impaired or overly sedated during an office visit or exam;
- (n) Requesting reported drugs by street name, color, or identifying marks;
- (o) Frequently requesting early refills of reported drugs;
- (p) Frequently losing prescriptions for reported drugs;
- (q) A history of illegal drug use;
- (r) Sharing reported drugs with another person; or
- (s) Recurring visits to non-coordinated sites of care, such as emergency departments, urgent care facilities, or walk-in clinics to obtain reported drugs.

Example: Getting into trouble

- Ohio family practitioner
- Pharmacists reported “Red Flags”
- Adipex, Percocet, Benzo
- Search and Seizure
- 2 years later dawn arrest
- 263 felony counts
- Trafficking, laundering, corrupt pattern
- Five million bail, 5 year plea offered, rejected
- Jury verdict guilty, Sentence 113 years

Another Story

- Board Certified Internist
- Begins to offer obesity Rx
- Rx's Schedule III anorectics (anorexiants) phentermine, phenmetrazine, along with diet, exercise, lifestyle counseling
- Unaware of state rules on anorectics
- Medical Board: Permanent revocation, stayed, indefinite suspension, minimum one year

Another Story

- Board Certified Internist
- Same state, different county
- Attends week-long obesity CME course in NY
- Begins to offer obesity Rx
- Rx's Schedule III anorectics along with diet, exercise, lifestyle counseling
- Unaware of Ohio rules on anorectics
- Undercover patient
- Indicted on 97 felony counts

It's True!

4:24:57

Record-keeping Pitfalls

- We were taught charting 101 in medical school and residency
- S.O.A.P. notes, P.O.M.R.
- Lawrence Weed, M.D., CWRU 1968
- Worked well for us
- But at least for me, that was 35 years ago
- And the teaching still hasn't changed much
- 1972 vs. 2018

Documentation Today

- S.O.A.P. notes now obsolete
- HIPAA requires HCPCS, CPT, CDT, ICD-10 records
- While most Medical Boards require "professionally acceptable" records, which might mean defensible S.O.A.P. notes, or
- Whatever you were taught in a good medical school and residency.
- The Feds and all payors require something else.

Is all this making for better patient care?

- *Tethered to the EHR: Primary Care Physician Workload Assessment Using EHR Event Log Data and Time-Motion Observations*
- *https://doi.org/10.1370/afm.2121*
- *September/October 2017 issue*

Methods

- **METHODS** We conducted a retrospective cohort study of 142 family medicine physicians in a single system in southern Wisconsin. All Epic (Epic Systems Corporation) EHR interactions were captured from “event logging” records over a 3-year period for both direct patient care and non-face-to-face activities, and were validated by direct observation. EHR events were assigned to 1 of 15 EHR task categories and allocated to either during or after clinic hours.

4:30:55

Results

- Clinicians spent 355 minutes (5.9 hours) of an 11.4-hour workday in the EHR per weekday per 1.0 clinical full-time equivalent: 269 minutes (4.5 hours) during clinic hours and 86 minutes (1.4 hours) after clinic hours. Clerical and administrative tasks including documentation, order entry, billing and coding, and system security accounted for nearly one-half of the total EHR time (157 minutes, 44.2%). Inbox management accounted for another 85 minutes (23.7%).

This IS NOT Just Medicare

- Rules apply to all Payors, not just M&M.
- The Commercial Carriers are in this too.
- Rules apply to all providers, not just M.D.'s.
- All have fraud control units.
- Task Force coordination.

The Law

- False Claims Act
- Mail Fraud, any form of the “mail”
- Fraud and Abuse, Stark, Kickback
- QUI TAM Actions
- Health Insurance Portability and Accountability Act (HIPAA)
- Emergency Medical Transportation and Active Labor Act (EMTALA)
- PPACA, Etc., Etc., Etc.

False Claims Act

- Requires that defendant "knowingly presented or caused to be presented a false claim."
- Knowingly is "the deliberate ignorance of the truth or falsity of the claim" *or*
- "Reckless disregard of the truth or falsity of the claim."

“Reckless Disregard”
“Deliberate Ignorance”

- Confessions to the FBI:
- It’s not my job. I have a billing service.
- The “girls” do all the billing.
- My concern is “Quality Care for My Patients.”
- We’ve always done it this way.
- I don’t have time to read this stuff.
- I haven’t looked at a CPT book in 3 years.
- What newsletters?
- I don’t know when she last went to a coding course.

Required Reading
October 5, 2000 Physician Compliance Guidance

- http://www.oig.hhs.gov/fraud/complianceguidance.html
- 65 Fed. Reg. 59434
- There appear to be significant misunderstandings within the physician community regarding the critical differences between what the Government views as innocent ''erroneous'' claims on the one hand and ''fraudulent'' (intentionally or recklessly false) health care claims on the other. Some physicians feel that Federal law enforcement agencies have maligned medical professionals, in part, by a perceived focus on innocent billing errors. These physicians are under the impression that innocent billing errors can subject them to civil penalties, or even jail. These impressions are mistaken.
- "A Lawyer from the Dark Side" says:
- "This is not true!"

5:08:47

“Innocent” Errors?

- “I would never bill for a test or a service I didn’t actually do!”
- “But I did the work!”
- But can you prove it to them?
- With the proof they ACCEPT?
- Remember “We don’t prosecute innocent errors”?

Cleveland Ambulette Prosecutions 2005

CLEVELAND.COM
Everything Cleveland

THE PLAIN DEALER

Van firms take Medicaid for a ride

$4 million billed for driving patients

Thursday, February 16, 2006

Mike Tobin
Plain Dealer Reporter

At least seven area transportation companies have scammed Medicaid out of about $4 million, and others remain under investigation.

FBI agents last week raided a Cleveland company, Love's Transporting Service, seizing receipts and records. No one has yet been charged.

The raid came two weeks after Vadim and Sabrina Arutyunov of Lift Medical Transportation in Mayfield Heights were put under three months house arrest and ordered to pay $60,000 in restitution. They admitted they billed Medicaid for driving patients not eligible for the service to doctor appointments.

"It's basically become a federally subsidized taxi service," Assistant U.S. Attorney Richard Blake said.

Twelve people working for seven "ambulette" companies have pleaded guilty in U.S. District Court to charges including conspiracy and health care fraud.

Poor people who rely on Medicaid to pay their medical bills are eligible for vouchers to get to and from doctor appointments. Often those vouchers come in the form of bus passes, Blake said.

But Medicaid recipients who are confined to wheelchairs are taken to and from doctor appointments by private ambulette companies in vans equipped with wheelchair lifts.

The companies bill Medicaid and are usually paid $70 per round trip.

The company officials who pleaded guilty admitted they transported hundreds of Medicaid recipients who did not qualify.

Many of the companies advertised free transportation for Medicaid recipients. They often loaded six or seven people into a van, then billed Medicaid for individual trips.

They often took people not confined to wheelchairs to methadone clinics, sometimes stopping for errands on the way back, prosecutors said.

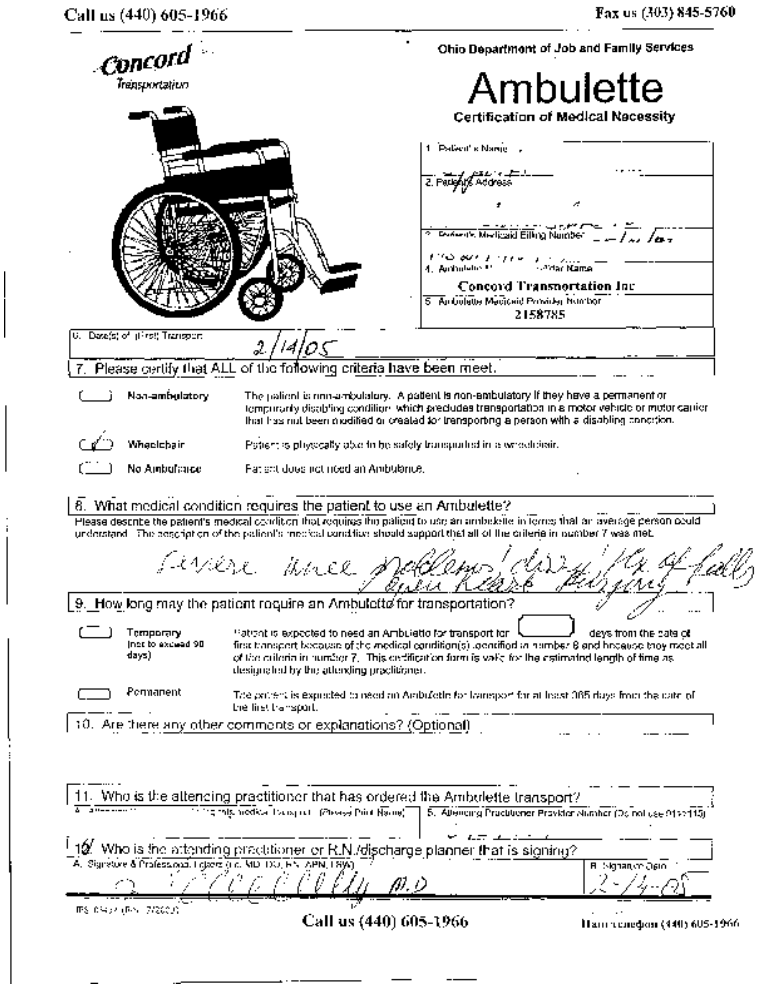
"They liked the methadone clinics because they operated seven days a week," Blake said. "You can still see them double-parked outside the clinics."

Investigators became suspicious after more than 100 such ambulette companies sprang up in Cuyahoga County.

"It didn't make sense that there were that many companies," Assistant U.S. Attorney Virginia Hearey said. "There's not that many people who need the service."

5:09:13

TYPICAL CMN



Call us (440) 605-1966 Fax us (303) 845-5760

Concord Transportation

Ohio Department of Job and Family Services

Ambulette

Certification of Medical Necessity

1. Patient's Name
2. Patient's Address
3. Patient's Medicaid Billing Number
4. Ambulette Carrier Name: Concord Transportation Inc
5. Ambulette Medicaid Provider Number: 2158785

6. Date(s) of First Transport: 2/14/05

7. Please certify that ALL of the following criteria have been meet.

- ☐ Non-ambulatory — The patient is non-ambulatory. A patient is non-ambulatory if they have a permanent or temporarily disabling condition which precludes transportation in a motor vehicle or motor carrier that has not been modified or created for transporting a person with a disabling condition.
- ☑ Wheelchair — Patient is physically able to be safely transported in a wheelchair.
- ☐ No Ambulance — Patient does not need an Ambulance.

8. What medical condition requires the patient to use an Ambulette?

Please describe the patient's medical condition that requires the patient to use an ambulette in terms that an average person could understand. The description of the patient's medical condition should support that all of the criteria in number 7 was met.

Severe knee problems / Hx of falls

9. How long may the patient require an Ambulette for transportation?

- ☐ Temporary (not to exceed 90 days) — Patient is expected to need an Ambulette for transport for ____ days from the date of first transport because of the medical condition(s) identified in number 8 and because they meet all of the criteria in number 7. This certification form is valid for the estimated length of time as designated by the attending practitioner.
- ☐ Permanent — The patient is expected to need an Ambulette for transport for at least 365 days from the date of the first transport.

10. Are there any other comments or explanations? (Optional)

11. Who is the attending practitioner that has ordered the Ambulette transport?

A. Signature of Ordering Medical Practitioner (Please Print Name) — B. Attending Practitioner Provider Number (Do not use 0000115)

12. Who is the attending practitioner or R.N./discharge planner that is signing?

A. Signature & Professional Degree (i.e. MD, DO, RN, APN, PA) — B. Signature Date: 2-14-05

IFS 6542 (Rev. 7/2003)

Call us (440) 605-1966 Fax us (440) 605-1966

5:09:14

The FBI in Action

5:13:46

Everything Goes

5:14:06

Seizure

5:15:38

Heavy!

5:17:50

The Good News: Morgantown FCI

"It looks more like a school campus as much as anything," said Sharon Cutright, who lives in the West Virginia community and works for the Morgantown Area Chamber of Commerce. "When you go by it, you don't even think of it as being a prison."

Morgantown has no fences, and most prisoners sleep on bunk beds in dorm-style buildings with 60 to 80 other inmates.

"They are able to move around freely," said Morgantown prison spokeswoman Veronica Fernandez. "But if they have a work assignment, they are accountable for being at that place."

The prison, with no guard towers, has six housing units and sits on 400 acres with homes and stores nearby.

Documentation "Guidelines" Surviving an Audit

- Medical Records and Documentation
- 1996 HIPAA and HCPCS (Healthcare Common Procedure Coding System)
- (The Privacy Act is the least of our worries)
- Which guidelines do you use, 1995 or 1997
- How an audit works

Audits

- You Get Paid Now
- They Demand Repayment Later (In a Big Lump Sum)
- Just a Few Charts-Statistically Extrapolated
- How They Audit Your Charts

Charting Requirements

- *Documentation Guidelines for Evaluation and Management Services,* published by CMS/AMA.
- "Currently, physicians may document based on the 1995 or 1997 E&M Guidelines, whichever is most advantageous to the physician."

5:34:42

Another Government Lie

- These are not “Guidelines”
- They are the LAW!
- There is no “MAY” about it.
- Either chart in accordance with these requirements or
- Pay it all back and/or
- Go directly to Jail (after paying it back)

Medicare claims processing manual

- 30.6 - Evaluation and Management Service Codes - General (Codes 99201 - 99499)
- (Rev. 178, 05-14-04)
- B3-15501-15501.1
- 30.6.1 - Selection of Level of Evaluation and Management Service
- (Rev. 1875, Issued: 12-14-09, Effective: 01-01-10, Implementation: 01-04-10)
- A. Use of CPT Codes
- Advise physicians to use CPT codes (level 1 of HCPCS) to code physician services, including evaluation and management services.

What must be documented

- Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported. 30.6.1 (A)

How must it be documented

- In the office or other outpatient setting where an evaluation is performed, physicians and qualified nonphysician practitioners shall use the CPT codes (99201 – 99215) depending on the complexity of the visit and whether the patient is a new or established patient to that physician. All physicians and qualified nonphysician practitioners shall follow the E/M documentation guidelines for all E/M services.
- 30.6.10
- Could it be any more clear?

Medicare Charting Requirement Specific Examples

Medicare Claims Processing Manual

- **G. Documentation for the IPPE or AWV**
- *Practitioners eligible to furnish an IPPE or an AWV* are required to use the 1995 and 1997 E/M documentation guidelines to document the medical record with the appropriate clinical information. *(http://xmarks.com/site/www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp)*. All referrals and a written medical plan must be included in this documentation. "Physicians, qualified NPPs, and medical professionals are required to use the 1995 and 1997 E/M documentation guidelines to document the medical record with the appropriate clinical information."
- 30.6.1 (G)

5:36:21

Another Example: Nursing Facility Care

- As with all E/M visits for Medicare Part B payment policy, the E/M documentation guidelines apply.
- 30.6.13 (A)
- There are multiple other examples in the claims processing manual.
- Conclusion: We must use the documentation guidelines. Nothing else will suffice.

The Very Basics
Time and Signature

- Chart when the work is done
- Delayed charting (>24 hours) is invalid
- Unsigned notes, orders, etc. are invalid
- Notes that don't comply with "Guidelines" are invalid
- Late notes: major repayment claim, $900,000
- Indefensible breach of contract
- No insurance coverage
- Settle is the best you can do

Example: General Physical

SPECIALTY EXAM: GENERAL MULTI-SYSTEM

HIC#	DATE OF SERVICE

Refer to data section (table below) in order to quantify. After reviewing the medical record documentation, identify the level of examination. Circle the level of examination within the appropriate grid in Section 5 (Page 3).

Performed and Documented	Level of Exam
One to five bullets	Problem Focused
At least six bullets	Expanded Problem Focused
At least two bullets from **each of six** body systems/areas **OR** at least twelve bullets in any two or more body systems/areas.	Detailed
At least two bullets from **each** of nine body systems/areas	Comprehensive

(Circle the bullets that are documented.)

NOTE: For the descriptions of the elements of examination containing the words "and", "and/or", only one (1) of those elements must be documented.

System/Body Area	Elements of Examination
Constitutional	• Measurement of **any three of the following seven** vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff) • General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming)
Eyes	• Inspection of conjunctivae and lids • Examination of pupils and irises (e.g., reaction to light and accommodation, size and symmetry) • Ophthalmoscopic examination of optic discs (e.g., size, C/D ratio, appearance) and posterior segments (e.g., vessel changes, exudates, hemorrhages)
Ears, Nose, Mouth and Throat	• External inspection of ears and nose (e.g., overall appearance, scars, lesions, masses) • Otoscopic examination of external auditory canals and tympanic membranes • Assessment of hearing (e.g., whispered voice, finger rub, tuning fork) • Inspection of lips, teeth and gums • Examination of oropharynx: oral mucosa, salivary glands, hard and soft palates, tongue, tonsils and posterior pharynx • Inspection of nasal mucosa, septum and turbinates

System/Body Area	Elements of Examination
Neck	• Examination of neck (e.g., masses, overall appearance, symmetry, tracheal position, crepitus) • Examination of thyroid (e.g., enlargement, tenderness, mass)
Respiratory	• Assessment of respiratory effort (e.g., intercostal retractions, use of accessory muscles, diaphragmatic movement) • Percussion of chest (e.g., dullness, flatness, hyperresonance) • Palpation of chest (e.g., tactile fremitus) • Auscultation of lungs (e.g., breath sounds, adventitious sounds, rubs)
Cardiovascular	• Palpation of heart (e.g., location, size, thrills) • Auscultation of heart with notation of abnormal sounds and murmurs Examination of: • Carotid arteries (e.g., pulse amplitude, bruits) • Abdominal aorta (e.g., size, bruits) • Femoral arteries (e.g., pulse amplitude, bruits) • Pedal pulses (e.g., pulse amplitude) • Extremities for edema and/or varicosities
Chest (Breasts)	• Inspection of breasts (e.g., symmetry, nipple discharge) • Palpation of breasts and axillae (e.g., masses or lumps, tenderness)
Gastrointestinal (Abdomen)	• Examination of abdomen with notation of presence of masses or tenderness • Examination of liver and spleen • Examination for presence or absence of hernia • Examination of anus, perineum and rectum, including sphincter tone, presence of hemorrhoids, rectal masses • Obtain stool sample for occult blood test when indicated

General Physical Page 2

SPECIALTY EXAM: GENERAL MULTI-SYSTEM (CONT.)

HIC#	DATE OF SERVICE

System/Body Area	Elements of Examination
Musculoskeletal **NOTE:** Determine the number of body areas addressed within each bullet. Enter that number on the corresponding line below. Total at the bottom of this box. Inspection and/or palpation: _____ Assessment of range of motion: _____ Assessment of stability: _____ Assessment of muscle strength: _____ * Total Bullets: _____ (including gait and station and inspection and/or palpation of digits and nails if circled)	• Examination of gait and station *(if circled, add to total at bottom of column to the left) • Inspection and/or palpation of digits and nails (e.g., clubbing, cyanosis, inflammatory conditions, petechiae, ischemia, infections, nodes) *(if circled, add to total at bottom of column to the left) Examination of joints, bones and muscles of **one or more of the following six** areas: 1) head and neck; 2) spine, ribs, and pelvis; 3) right upper extremity; 4) left upper extremity; 5) right lower extremity; and 6) left lower extremity. The examination of a given area includes: • Inspection and/or palpation with notation of presence of any misalignment, asymmetry, crepitation, defects, tenderness, masses, effusions • Assessment of range of motion with notation of any pain, crepitation or contracture • Assessment of stability with notation of any dislocation (luxation), subluxation or laxity • Assessment of muscle strength and tone (e.g., flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements
Skin	• Inspection of skin and subcutaneous tissue (e.g., rashes, lesions, ulcers) • Palpation of skin and subcutaneous tissue (e.g., induration, subcutaneous nodules, tightening)
Neurologic	• Test cranial nerves with notation of any deficits • Examination of deep tendon reflexes with notation of pathological reflexes (e.g., Babinski) • Examination of sensation (e.g., by touch, pin, vibration, proprioception)
Psychiatric	• Description of patient's judgement and insight Brief assessment of mental status including: • Orientation to time, place and person • Recent and remote memory • Mood and affect (e.g., depression, anxiety, agitation)

System/Body Area	Elements of Examination
Genitourinary	**MALE:** • Examination of the scrotal contents (e.g., hydrocele, spermatocele, tenderness of cord, testicular mass) • Examination of penis • Digital rectal examination of prostrate gland (e.g., size, symmetry, nodularity, tenderness) **FEMALE:** Pelvic examination (with or without specimen collection for smears and cultures), including: • Examination of external genitalia (e.g., general appearance, hair distribution, lesions) and vagina (e.g., general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele, rectocele) • Examination of urethra (e.g., masses, tenderness, scarring) • Examination of bladder (e.g., fullness, masses, tenderness) • Cervix (e.g., general appearance, lesions, discharge) • Uterus (e.g., size, contour, position, mobility, tenderness, consistency, descent or support) • Adnexa/parametria (e.g., masses, tenderness, organomegaly, nodularity)
Lymphatic	Palpation of lymph nodes in **two or more** areas: • Neck • Axillae • Groin • Other

(Enter the number of circled bullets in the boxes below. Then circle the appropriate level of care.)

EXAM				
	One to Five Bullets	Six to Eleven Bullets	This level requires that one of the following questions be answered with a "yes." Have you circled at least two bullets in each of six body systems/areas? ❒ Yes ❒ No Are there a total of twelve bullets circled in two or more body systems/areas? ❒ Yes ❒ No	At least two bullets from each of nine body systems/areas
	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive

5:43:09

Scoring Bullets

EVALUATION AND MANAGEMENT REVIEW SHEET 2/3

HISTORY OF PRESENT ILLNESS: Determine the number of elements described

- ✓ Location
- ___ Quality
- ___ Severity
- ___ Duration
- ___ Timing
- ___ Context
- ___ Modifying Factors
- ___ Associated Signs and Symptoms

REVIEW OF SYSTEMS AND EXAMINATION:

ROS	EXAM		ROS	EXAM		ROS	EXAM	
☐	⬭	Constitutional	☐	⬭	Gastrointestinal	☐	⬭	Psychiatric
☐	⬭	Eyes	☐	⬭	Genitourinary	☐	⬭	Hem/Lymph
☐	⬭	ENT	☐	⬭	Skin/Breast	☐	N/A	Endocrine
☐	⬭	Neck	☐	⬭	Musculoskeletal	☐	N/A	Allergy/Imm
☐	⬭	Cardiovascular	☐	⬭	Neurologic	☐	N/A	All Others Neg
☐	⬭	Respiratory						

A: HISTORY TYPE: Select the column with all 3 elements circle. If the circles are not in the same column, pick the one furthest to the left.

HPI	Brief 1-3	Brief 1-3	Extended ≥ 4	Extended ≥ 4
ROS	None	Prob Pert	Extended 2-9	Complete ≥10
PFSH	None	None	Pertinent 1	Complete 2 to 3
HISTORY TYPE	PF History	EXP PF History	Detailed History	Comprehensive

B: EXAMINATION TYPE

Limited Exam, Affected Area/System	Problem Focused Exam
As Above + up to 6 Others	Expanded Problem Focused Exam
Same As Above, More Detail	Detailed Exam
General Multisystem Exam (8 Systems)	Comprehensive Exam

C: DECISION MAKING: Identify each problem evaluated in the record. Enter the number, If the encounter is dominated by counseling or coordination of care, and the time is not specified, enter 3 for the total.

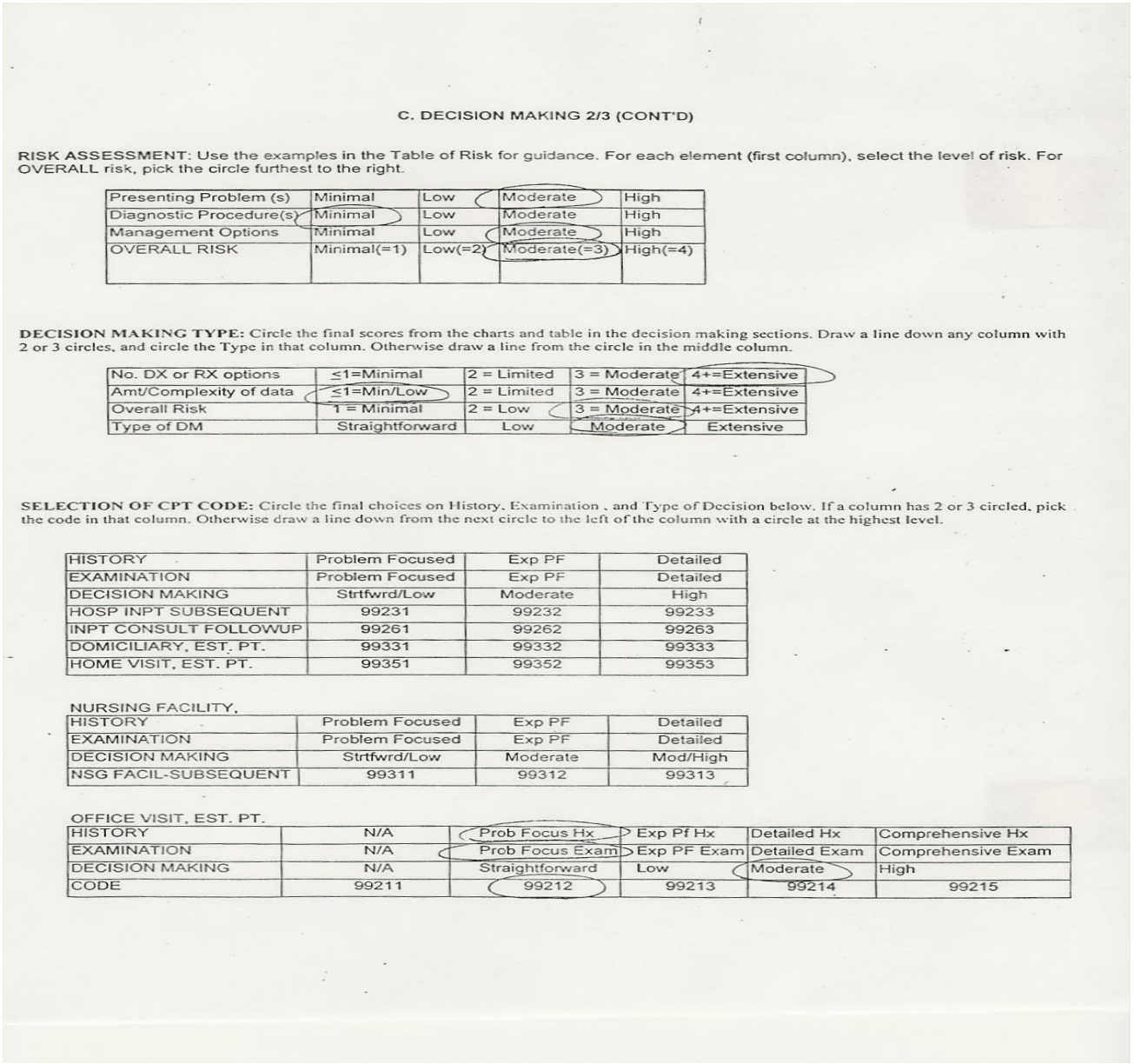
PROBLEM CATEGORIES	NUMBER X	POINTS =	SCORE
Self-limited or minor (stable, improving or worsening	(MAX = 2)	1	
Established DX/Problem, stable, improved		1	
Established DX/Problem, worsening		2	
New Problem, NO additional work up planned	(MAX = 1)	3	
New Problem, additional work up planned	1	4	4
		TOTAL	4

TYPE OF DATA

POINTS	TYPE OF DATA
1	Review and/or order of clinical lab tests
1	Review and/or order tests in 7XXXX series of CPT
1	Review and/or order tests in 9XXXX series of CPT
1	Discuss test results with performing physician
2	Independent review of image, tracing or specimen
1	Decision to obtain old records and/or obtain HX from others
2	Review AND summarize old records, and/or obtain HX
1	TOTAL

5:43:09

Missing Bullets



C. DECISION MAKING 2/3 (CONT'D)

RISK ASSESSMENT: Use the examples in the Table of Risk for guidance. For each element (first column), select the level of risk. For OVERALL risk, pick the circle furthest to the right.

Presenting Problem (s)	Minimal	Low	Moderate	High
Diagnostic Procedure(s)	Minimal	Low	Moderate	High
Management Options	Minimal	Low	Moderate	High
OVERALL RISK	Minimal(=1)	Low(=2)	Moderate(=3)	High(=4)

DECISION MAKING TYPE: Circle the final scores from the charts and table in the decision making sections. Draw a line down any column with 2 or 3 circles, and circle the Type in that column. Otherwise draw a line from the circle in the middle column.

No. DX or RX options	≤1=Minimal	2 = Limited	3 = Moderate	4+=Extensive
Amt/Complexity of data	≤1=Min/Low	2 = Limited	3 = Moderate	4+=Extensive
Overall Risk	1 = Minimal	2 = Low	3 = Moderate	4+=Extensive
Type of DM	Straightforward	Low	Moderate	Extensive

SELECTION OF CPT CODE: Circle the final choices on History, Examination , and Type of Decision below. If a column has 2 or 3 circled, pick the code in that column. Otherwise draw a line down from the next circle to the left of the column with a circle at the highest level.

HISTORY	Problem Focused	Exp PF	Detailed
EXAMINATION	Problem Focused	Exp PF	Detailed
DECISION MAKING	Strtfwrd/Low	Moderate	High
HOSP INPT SUBSEQUENT	99231	99232	99233
INPT CONSULT FOLLOWUP	99261	99262	99263
DOMICILIARY, EST. PT.	99331	99332	99333
HOME VISIT, EST. PT.	99351	99352	99353

NURSING FACILITY,

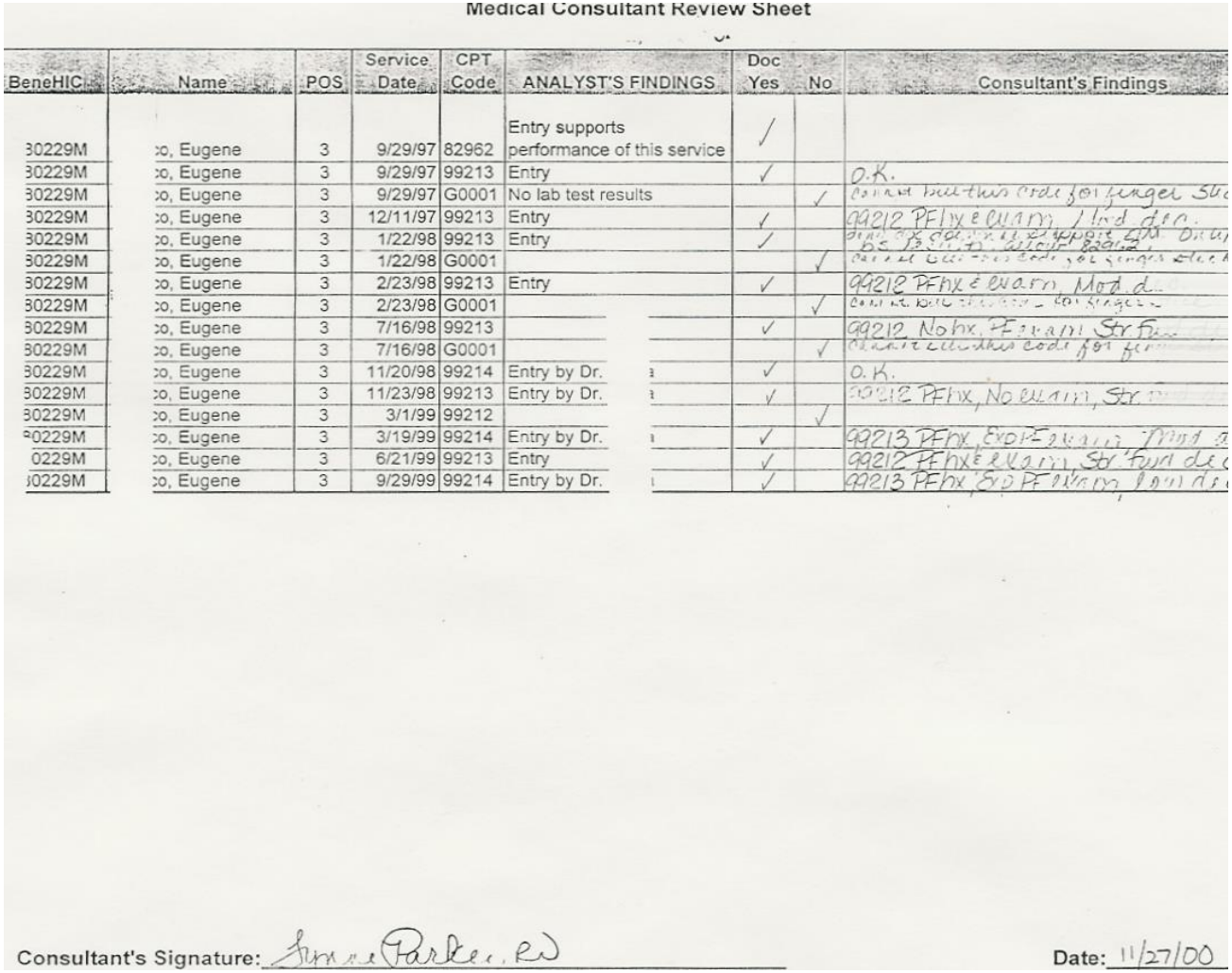
HISTORY	Problem Focused	Exp PF	Detailed
EXAMINATION	Problem Focused	Exp PF	Detailed
DECISION MAKING	Strtfwrd/Low	Moderate	Mod/High
NSG FACIL-SUBSEQUENT	99311	99312	99313

OFFICE VISIT, EST. PT.

HISTORY	N/A	Prob Focus Hx	Exp Pf Hx	Detailed Hx	Comprehensive Hx
EXAMINATION	N/A	Prob Focus Exam	Exp PF Exam	Detailed Exam	Comprehensive Exam
DECISION MAKING	N/A	Straightforward	Low	Moderate	High
CODE	99211	99212	99213	99214	99215

5:44:42

The Score Card



Medical Consultant Review Sheet

BeneHIC	Name	POS	Service Date	CPT Code	ANALYST'S FINDINGS	Doc Yes	No	Consultant's Findings
30229M	:o, Eugene	3	9/29/97	82962	Entry supports performance of this service	✓		
30229M	:o, Eugene	3	9/29/97	99213	Entry	✓		O.K.
30229M	:o, Eugene	3	9/29/97	G0001	No lab test results		✓	Cannot bill this code for finger Str
30229M	:o, Eugene	3	12/11/97	99213	Entry	✓		99212 PE hx & exam / Ind dec.
30229M	:o, Eugene	3	1/22/98	99213	Entry	✓		
30229M	:o, Eugene	3	1/22/98	G0001			✓	
30229M	:o, Eugene	3	2/23/98	99213	Entry	✓		99212 PE hx & exam Mod d
30229M	:o, Eugene	3	2/23/98	G0001			✓	
30229M	:o, Eugene	3	7/16/98	99213		✓		99212 No hx, PE exam, Str Fa
30229M	:o, Eugene	3	7/16/98	G0001			✓	Cannot bill this code for fi
30229M	:o, Eugene	3	11/20/98	99214	Entry by Dr.	✓		O.K.
30229M	:o, Eugene	3	11/23/98	99213	Entry by Dr.	✓		99212 PE hx, No exam, Str
30229M	:o, Eugene	3	3/1/99	99212			✓	
30229M	:o, Eugene	3	3/19/99	99214	Entry by Dr.	✓		99213 PE hx, Exp PE exam, Mod d
0229M	:o, Eugene	3	6/21/99	99213	Entry	✓		99212 PE hx & exam, Str fund dec
30229M	:o, Eugene	3	9/29/99	99214	Entry by Dr.	✓		99213 PE hx, Exp PE exam, Low d

Consultant's Signature: Susan Parker, RN

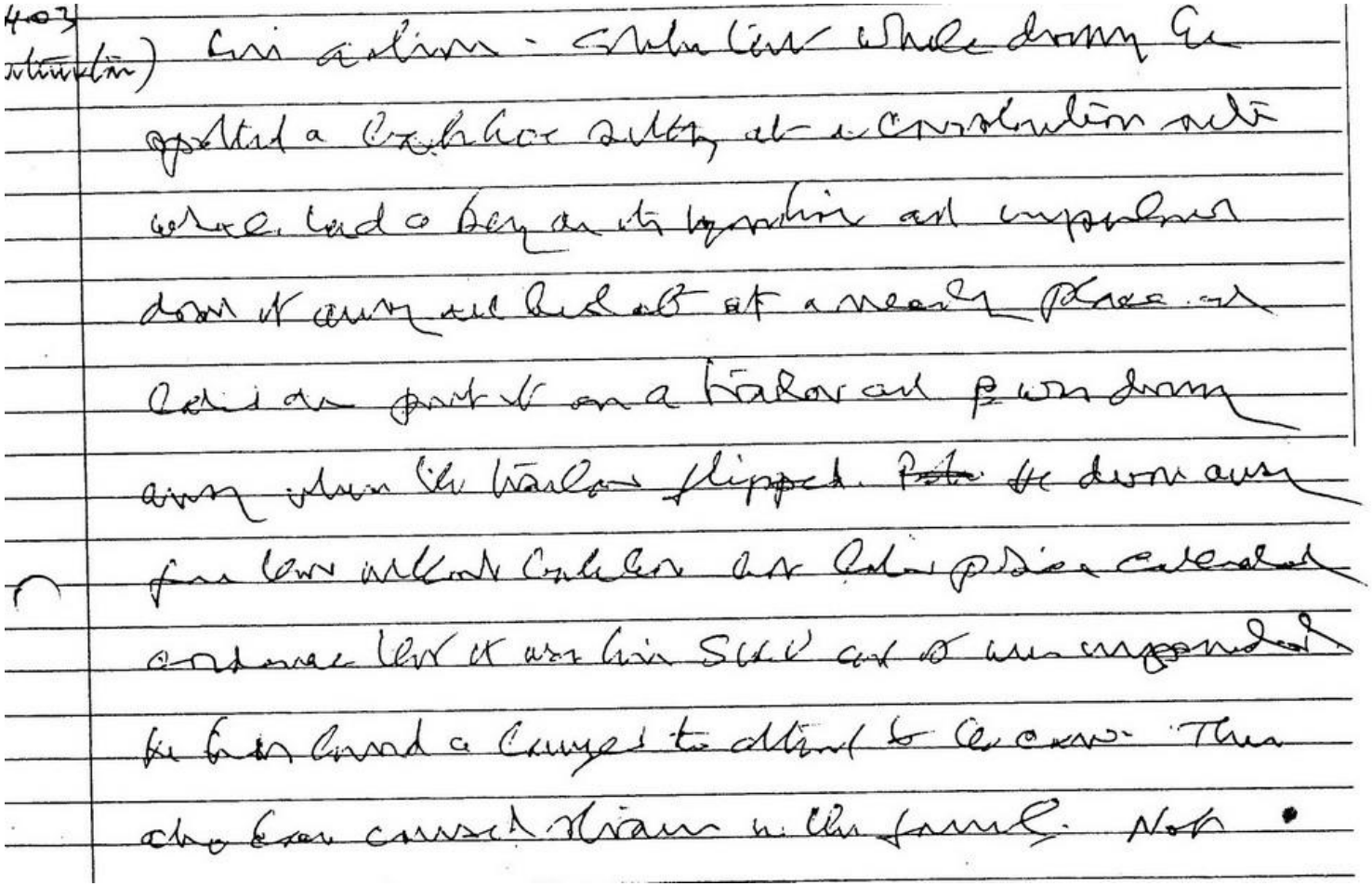
Date: 11/27/00

5:45:41

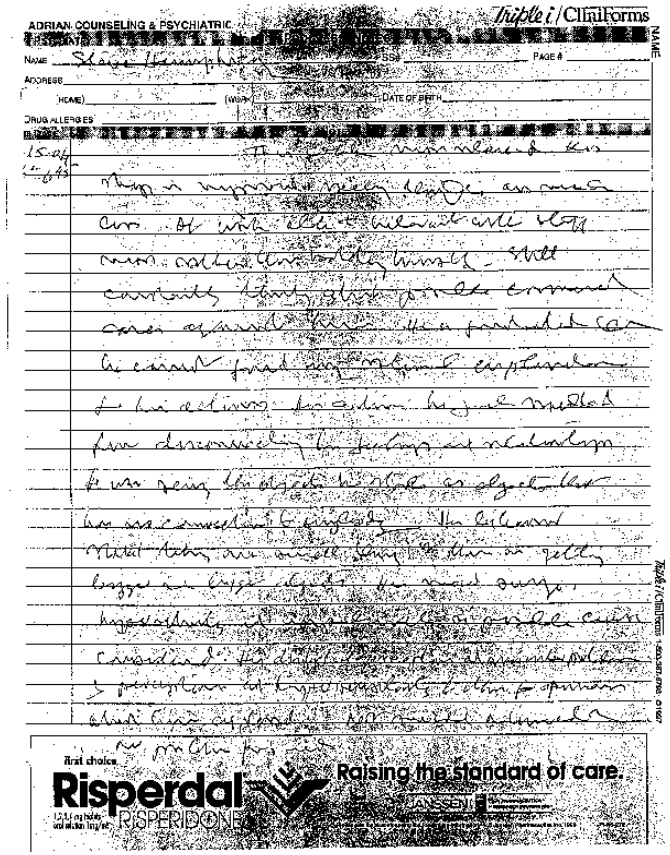
E&M Bullets and Office Notes

- Every single bullet MUST be present.
- Otherwise deny, deny, deny and extrapolate and then repay, repay and repay.
- Just like a tax deduction, if you can't prove it, you can't have it!
- Sadly, nobody ever taught us this stuff.

Could This Withstand an Audit?



Could you defend yourself with this?

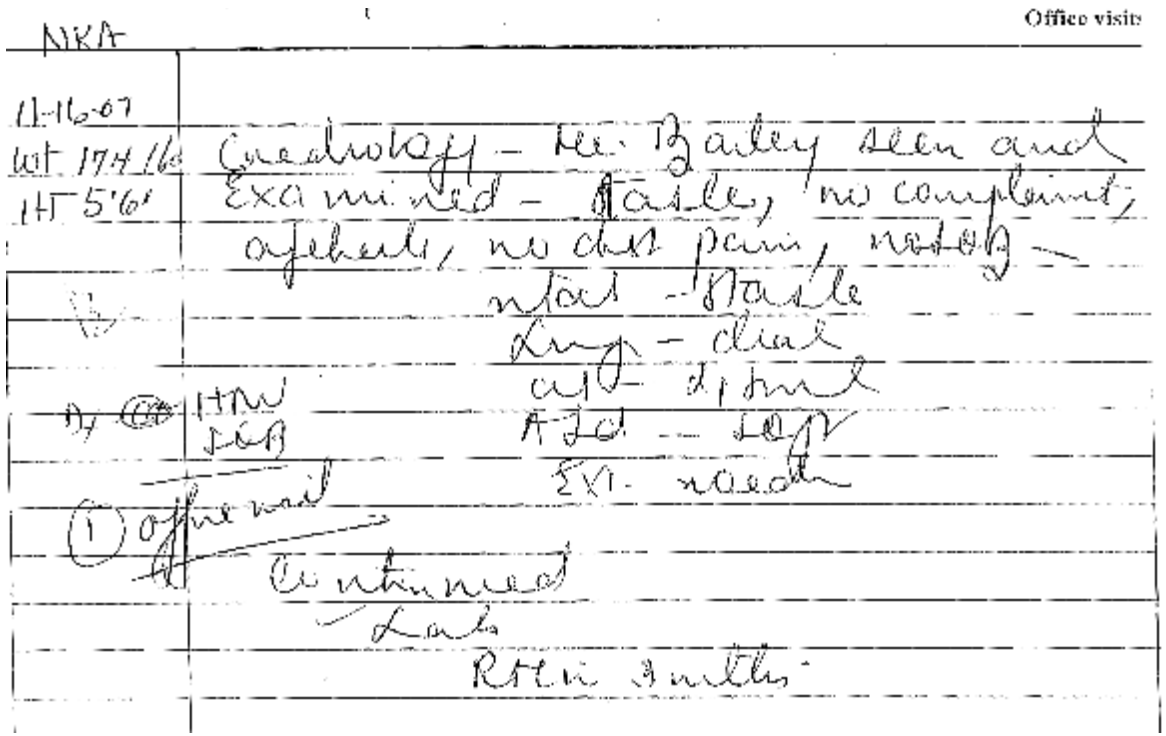


5:46:00

Let's audit a few of these

5:48:43

The Office Note



The Auditor's Opinion

- DOS 11/16/2007 This service was coded as 99214 for 401.1 and 786.00
- The documentation for this date of service consisted of a summary statement of "seen and examined," stable, no complaints, no chest pain or SOB. As history this was an HPI of context, quality, symptom review (expanded problem focused). The exam included heart, lungs, abdomen and extremity. There was no reference to blood pressure the 174/65 was weight not BP. The diagnosis of HTN and SOB. The SOB was not supported in exam or history. The medications were continued.
- This service was a 99213 as documented and the issue of the 786.00 being used as a diagnosis problematic.

Example Audits

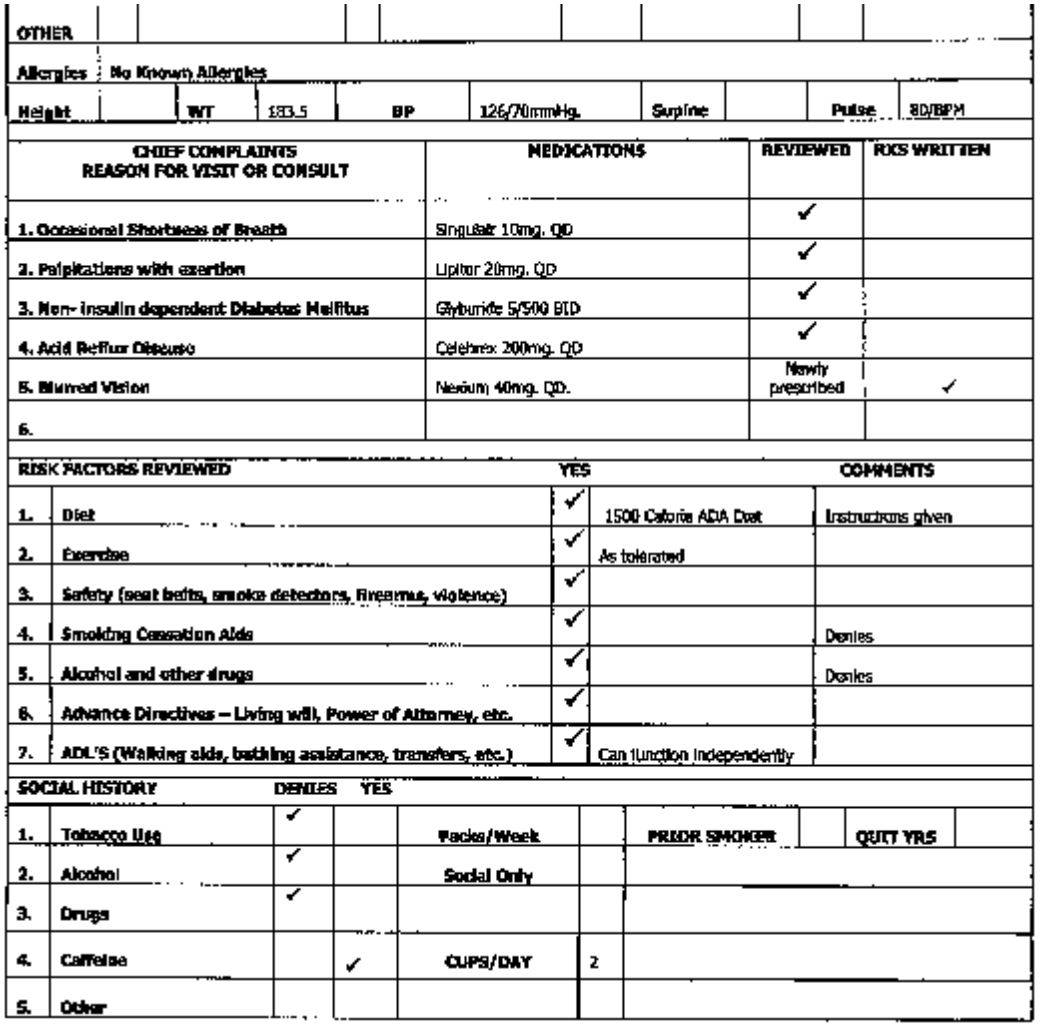
- 2 M.D.'s, one payor, Medicare, one code 99223, over one million dollars
- 2 M.D.'s, one payor, MMOH, multiple codes, $1.2 million
- 1 Ph.D., two payors, MMOH, Anthem, two codes, one felony conviction
- 1 M.D., one payor, MMOH, $700K, fraud claim, bankruptcy, pro se

Cascade of Consequences

- Medicaid Audit. 200 Charts. Software “glich”. $11,000. M-1, Excluded, OOP
- BWC Audit, CPT 90805, $247.00, $70,000 costs. OOP
- Prescribed to family, Reprimand and 2 years probation. Medicaid, 3rd party payors, ABIM, Hospital privileges, employment terminated, OOP

5:57:45

So Let's Meaningfully Use an EMR



OTHER									
Allergies	No Known Allergies								
Height		WT	183.5	BP	126/70mmHg.	Supine		Pulse	80/BPM

CHIEF COMPLAINTS REASON FOR VISIT OR CONSULT	MEDICATIONS	REVIEWED	ROS WRITTEN
1. Occasional Shortness of Breath	Singulair 10mg. QD	✓	
2. Palpitations with exertion	Lipitor 20mg. QD	✓	
3. Non- insulin dependent Diabetes Mellitus	Glyburide 5/500 BID	✓	
4. Acid Reflux Disease	Celebrex 200mg. QD	✓	
5. Blurred Vision	Nexium 40mg. QD.	Newly prescribed	✓
6.			

RISK FACTORS REVIEWED		YES		COMMENTS
1.	Diet	✓	1500 Calorie ADA Diet	Instructions given
2.	Exercise	✓	As tolerated	
3.	Safety (seat belts, smoke detectors, firearms, violence)	✓		
4.	Smoking Cessation Aids	✓		Denies
5.	Alcohol and other drugs	✓		Denies
6.	Advance Directives – Living will, Power of Attorney, etc.	✓		
7.	ADL'S (Walking aids, bathing assistance, transfers, etc.)	✓	Can function independently	

SOCIAL HISTORY		DENIES	YES						
1.	Tobacco Use	✓		Packs/Week		PRIOR SMOKER		QUIT YRS	
2.	Alcohol	✓		Social Only					
3.	Drugs	✓							
4.	Caffeine		✓	CUPS/DAY	2				
5.	Other								

Page 2 EMR

PAST MEDICAL HISTORY	REVIEWED	FAMILY HISTORY	REVIEWED
Non-Insulin dependent Diabetes Mellitus	✓	Hypertenston	✓
Asthma	✓	Coronary Artery Disease	✓
Hyperlipidemia	✓		
Acid Reflux Disease	✓		
Osteoarthritis	✓		
		PAST SURGICAL HISTORY	REVIEWED
		Knee Replacement	✓

ROS	☑**General**-Denies fatigue, denies malaise, fever or weight loss	☑**Gastrointestinal**-Denies abdominal pain, dysphasia, nausea, vomiting, and constipation, complaints of acid reflux.	☑**Cardiovascular**- Some chest pain, occasional palpitations, denies paroxysmal nocturnal dyspnea, orthopnea, and edema.
	☑ **HEENT**-Denies ear pain, discharge, nasal obstruction, discharge, or sore throat	☑ **Genitourinary**-Denies hematuria, frequency, urgency, discharge, dysuria, incontinence.	☑ **Psychiatric**-Denies depression, anxiety, difficulty sleeping, hallucinations, paranoia.
	☑**Respiratory**-Denies, coughing, wheezing, denies dyspnea, hemoptysis, some SOB on exertion.	☑ **Neurologic**-Denies syncope, seizures, transient paralysis, weakness, paresthesias.	☑ **Skin**- Denies rashes, ecchymosis, ulcers, or nodules
	☑**Hema/Lymph**-Denies Bleeding Gums, unusual bruising, swollen lymph nodes.	☑**Musculoskeletal**-Denied myalgias, recent trauma, fractures, joint swelling, S/P Knee Replacement.	☑**Eyes**-Denies diplopia, irritation or discharge, complaints of blurring.

PHYSICAL EXAM - (VITALS AS NOTED ABOVE)

EYE	Normal	**EXT**	No edema, peripheral pulses normal and symmetric.
ENT	Normal	**NEURO**	Alert, oriented x 3, no focalities
NECK	Supple, no lymphadenopathy, no thyromegaly, no JVD, brisk carotid pulses with no bruits.	**PSCHY**	Alert, oriented to person, place and time.
CV	Regular rate and rhythm, clear S1-S2, no rubs, gallop, or clicks, soft systolic murmur heard.		
LUNGS	Clear to auscultation and percussion with normal respiratory effort, few rhonchi, no wheezing, no rales.		
ABDOM	Benign and soft, non-tender, no palpable masses, bowel sounds present.		
BREASTS	Deferred.		
LYMPHS	No cervical, axillary, or inguinal adenopathy.		
SKIN	Clear, color normal, no rashes, lesions or ulcerations.		

5:58:28

Page 3

CARDIAC TESTING	YES	NO	FINDINGS	DATE
EKG				
ECHOCARDIOGRAM	✓		Last completed, was within the normal limits	Last completed 08/09 2008
STRESS TEST	✓		Last completed was three years ago and results were normal, with no evidence of reversible Ischemia seen.	10/03 /2008
HOLTER MONITOR		✓		
CAROTID DOPPLER	✓		Last completed , within the normal limits	08/09/2008
PVR	✓		Last completed, within the normal limits	08/09/2008
AORTA SCAN	✓		Last completed, within the normal limits	08/09/2008
CHEST XRAY		✓		

ASSESMENT/TREATMENT PLAN:

1. Cardiac status is stable, with no noted abnormalities.
2. Complete Lab panels to be ordered, including CMP, CBD/Diff, Lipid Panel, Thyroid Panel, HgA1C, and Urinalysis. Once completed results to be discussed and if indicated any changes in medications will be addressed accordingly.
3. To address patient's complaints of Acid Reflux, Nexium 40mg. QD, to be started. If patient has no relief will further discuss referral to GI physician to further evaluate.
4. Referred to Ophthalmologist due to patient's complaints of blurred vision.
5. Patient instructed to follow a 1500 cal ADA diet. Patient was given Clinical dietician's number to further instruct on diet, if needed.
6. Return for follow up appointment in 3 months.

Time Spent with patient: 35 minutes

Let's look at that ROS and PE again

ROS	☑**General**-Denies fatigue, denies malaise, fever or weight loss	☑**Gastrointestinal**-Denies abdominal pain, dysphasia, nausea, vomiting, and constipation. complaints of acid reflux.	☑**Cardiovascular**- Some chest pain, occasional palpitations, denies paroxysmal nocturnal dyspnea, orthopnea, and edema.
	☑ **HEENT**-Denies ear pain, discharge, nasal obstruction, discharge, or sore throat	☑ **Genitourinary**-Denies hematuria, frequency, urgency, discharge, dysuria, incontinence.	☑ **Psychiatric**-Denies depression, anxiety, difficulty sleeping, hallucinations, paranoia.
	☑**Respiratory**-Denies, coughing, wheezing, denies dyspnea, hemoptysis, some SOB on exertion.	☑ **Neurologic**-Denies syncope, seizures, transient paralysis, weakness, paresthesias.	☑ **Skin**- Denies rashes, ecchymosis, ulcers, or nodules
	☑**Hema/Lymph**-Denies Bleeding Gums, unusual bruising, swollen lymph nodes.	☑**Musculoskeletal**-Denied myalgias, recent trauma, fractures, joint swelling, S/P Knee Replacement.	☑**Eyes**-Denies diplopia, irritation or discharge, complaints of blurring.

PHYSICAL EXAM - (VITALS AS NOTED ABOVE)

EYE	Normal	**EXT**	No edema, peripheral pulses normal and symmetric.
ENT	Normal	**NEURO**	Alert, oriented x 3, no focalities
NECK	Supple, no lymphadenopathy, no thyromegaly, no JVD, brisk carotid pulses with no bruits.	**PSCHY**	Alert, oriented to person, place and time.
CV	Regular rate and rhythm, clear S1-S2, no rubs, gallop, or clicks, soft systolic murmur heard.		
LUNGS	Clear to auscultation and percussion with normal respiratory effort, few rhonchi, no wheezing, no rales.		
ABDOM	Benign and soft, non-tender, no palpable masses, bowel sounds present.		
BREASTS	Deferred.		
LYMPHS	No cervical, axillary, or inguinal adenopathy.		
SKIN	Clear, color normal, no rashes, lesions or ulcerations.		

Next Patient ROS and PE

ROS	☑**General**-Some fatigue, denies malaise, fever or weight loss	☑**Gastrointestinal**-Denies abdominal pain, dysphasia, nausea, vomiting, and constipation.	☑**Cardiovascular**-Some left sided chest pain, some occasional palpitations, denies paroxysmal nocturnal dyspnea, orthopnea, edema.
	☑ **HEENT**-Denies ear pain, discharge, nasal obstruction, discharge, or sore throat	☑ **Genitourinary**-Denies hematuria, frequency, urgency, discharge, dysuria, incontinence.	☑ **Psychiatric**-Denies depression, anxiety, difficulty sleeping, hallucinations, paranoia.
	☑**Respiratory**-Denies, coughing, wheezing, dyspnea, hemoptysis, some SOB with exertion.	☑ **Neurologic**-Denies syncope, seizures, transient paralysis, weakness, paresthesias.	☑ **Skin**- Denies rashes, ecchymosis, ulcers, or nodules
	☑**Hema/Lymph**-Denies Bleeding Gums, Unusual bruising, swollen lymph nodes.	☑**Musculoskeletal**-Denied myalgias, recent trauma, fractures, joint swelling.	☑**Eyes**-Denies blurring, diplopia, irritation or discharge.

PHYSICAL EXAM - (VITALS AS NOTED ABOVE WITHIN NORMAL LIMITS)

EYE	Normal	**EXT**	No edema, peripheral pulses normal and symmetric.
ENT	Normal	**NEURO**	Alert, oriented x 3, no focalities
NECK	Supple, no lymphadenopathy, no thymomegaly, no JVD, brisk carotid pulses with no bruits.	**PSCHY**	Alert, oriented to person, place and time.
CV	Regular rate and rhythm, clear S1-S2, no rubs, gallop, or clicks, soft systolic murmur heard.		
LUNGS	Clear to auscultation and percussion with normal respiratory effort, few rhondi, no rales.		
ABDOM	Benign and soft, non-tender, no palpable masses, bowel sounds present.		
BREASTS	No masses, no lumps detected.		
LYMPHS	No cervical, axillary, or inguinal adenopathy.		
SKIN	Clear, color normal, no rashes, lesions or ulcerations.		

Patient 3 ROS and PE

ROS	☑**General**-Denies fatigue, denies malaise, fever or weight loss	☑**Gastrointestinal**-Denies abdominal pain, dysphasia, nausea, vomiting, and constipation.	☑**Cardiovascular**- Denies chest pain, palpitations, paroxysmal nocturnal dyspnea, orthopnea, edema.
	☑ **HEENT**-Denies ear pain, discharge, nasal obstruction, discharge, or sore throat	☑ **Genitourinary**-Denies hematuria, frequency, urgency, discharge, dysuria, incontinence.	☑ **Psychiatric**-Denies depression, anxiety, difficulty sleeping, hallucinations, paranoia.
	☑**Respiratory**-Denies, coughing, some wheezing, denies dyspnea, hemoptysis, or shortness of breath.	☑ **Neurologic**-Denies syncope, seizures, transient paralysis, weakness, paresthesias.	☑ **Skin**- Denies rashes, ecchymosis, ulcers, or nodules
	☑**Hema/Lymph**-Denies Bleeding Gums, unusual bruising, swollen lymph nodes.	☑**Musculoskeletal**-Denied myalgias, recent trauma, fractures, joint swelling.	☑**Eyes**-Denies blurring, diplopia, irritation or discharge.

PHYSICAL EXAM - (VITALS AS NOTED ABOVE)

EYE	Normal	**EXT**	No edema, 1/ 2+ peripheral pulses.
ENT	Normal	**NEURO**	Alert, oriented x 3, no focalities
NECK	Supple, no lymphadenopathy, no thyromegaly, no JVD, brisk carotid pulses with no bruits.	**PSCHY**	Alert, oriented to person, place and time.
CV	Regular rate and rhythm, clear S1-S2, no rubs, gallop, or clicks, soft systolic murmur heard.		
LUNGS	Clear to auscultation and percussion with normal respiratory effort, few rhondi, some wheezing, no rales.		
ABDOM	Benign and soft, non-tender, no palpable masses, bowel sounds present, inguinal hernia noted.		
BREASTS	Deferred.		
LYMPHS	No cervical, axillary, or inguinal adenopathy.		
SKIN	Clear, color normal, no rashes, lesions or ulcerations.		

Patient 4 ROS and PE

ROS	☑**General**-Denies fatigue, denies malaise, fever or weight loss	☑**Gastrointestinal**-Denies abdominal pain, dysphesia, nausea, vomiting, and constipation.	☑**Cardiovascular**- Denies chest pain, palpitations, denies paroxysmal nocturnal dyspnea, orthopnea, and edema.
	☑ **HEENT**-Denies ear pain, discharge, nasal obstruction, discharge, or sore throat	☑ **Genitourinary**-Denies hematuria, frequency, urgency, discharge, dysuria, incontinence.	☑ **Psychiatric**-Denies depression, anxiety, difficulty sleeping, hallucinations, paranoia.
	☑**Respiratory**-Denies, coughing, wheezing, denies dyspnea, hemoptysis.	☑ **Neurologic**-Denies syncope, seizures, transient paralysis, weakness, paresthesias.	☑ **Skin**- Denies rashes, ecchymosis, ulcers, or nodules
	☑**Hema/Lymph**-Denies Bleeding Gums, unusual bruising, swollen lymph nodes.	☑**Musculoskeletal**-Denied myalgias, recent trauma, fractures, complaints of general osteoarthritis.	☑**Eyes**-Denies blurring, diplopia, irritation or discharge.

PHYSICAL EXAM - (VITALS AS NOTED ABOVE within the normal limits)

EYE	Normal	**EXT**	No edema, 1 / 2+ pulses
ENT	Normal	**NEURO**	Alert, oriented x 3, no focalities
NECK	Supple, no lymphadenopathy, no thyromegaly, no JVD, brisk carotid pulses with no bruits.	**PSCHY**	Alert, oriented to person, place and time.
CV	Regular rate and rhythm, clear S1-S2, no rubs, gallop, or clicks, soft systolic murmur heard.		
LUNGS	Clear to auscultation and percussion with normal respiratory effort, few rhonchi, no wheezing, no rales.		
ABDOM	Benign and soft, non-tender, no palpable masses, bowel sounds present.		
BREASTS	Deferred.		
LYMPHS	No cervical, axillary, or inguinal adenopathy.		
SKIN	Clear, color normal, no rashes, lesions or ulcerations.		

Beware of “Cloning” and “Exploding” Records

- Cloning: push a button and the same old stuff is filled in. Cutting and Pasting at its best. Just repeat a template over and over.
- Exploding: A simple macro or keyboard shortcut.
- Looks great in one chart. Looks hideous when you line up ten charts.

Cloned Records

Audit Findings:

1) **E/M Accuracy rate = 25%**
   - 2 services coded correctly
   - 6 services incorrectly coded
     - Billed 99213; documentation supported 99214
2) It appears that the notes were "cloned" because:
   - All 8 patients received a 10 system exam:
     - A 99213 only requires a 2-7 system exam;
     - A 99214 only requires a 2-7 system exam, with 1 system detailed.
   - The exam findings were exactly the same for every patient regardless of the chief complaint.
   - Finally, each note stated that "the otoscopic examination was negative." However, it is unclear whether this type is equipment is available in every exam room.

Theory v. Reality

- In theory you can document anyway you want, as long as the 1995 or 1997 elements or bullets are (legibly) recorded.
- Free hand, free dictation, S.O.A.P. notes, templates, electronic records.
- In reality, EMR's only, but
- WATCH OUT FOR THE LANDMINES
- Medical Decision Making drives the code
- Speech Recognition allows you to prove it.

Telemedicine

- SMBO historical opposition to Telemedicine
- Internet prescribing
- Telemedicine Certificate
- Repealed
- Subsumed in Certificate
- Covid-19

March 9, 2020 Board Notice

- **State Medical Board of Ohio**
- Effective March 9, 2020, providers can use telemedicine in place of in-person visits. Throughout the declared Covid-19 emergency, the SMBO will not enforce in-person visit requirements normally required in SMBO rules. Suspension of these enforcement requirements includes, but is not limited to:
- Prescribing controlled substances
- Prescribing for subacute and chronic pain
- Prescribing to patients not seen by the provider
- Pain management
- Medical marijuana recommendations and renewals
- Office-based treatment for opioid addiction

Required documentation

- Providers must document their use of telemedicine and meet minimal standards of care. The Medical Board will provide advance notice before resuming enforcement of the above regulation when the state emergency orders are lifted.

Ohio Medicaid

- OAC 5160-1-18
- Specific locations, payment conditions:
- All services provided via telehealth shall be provided in accordance with all state and federal laws including the Health Insurance Portability and Accountability Act of 1996 (HIPAA)and 4
- Evaluation and management of an established patient described as "office or other outpatient visit" with medical decision making not to exceed moderate complexity.
- Inpatient or office consultation for a new or established patient when providing the same quality and timeliness of care to the patient other than by telehealth is not possible, as documented in the medical record.
- Mental health or substance use disorder services described as "psychiatric diagnostic evaluation" or "psychotherapy."2 C.F.R. part 2 (as in effect on January 1, 2019).

DEA January 31, 2020 Emergency

- For as long as the Secretary's designation of a public health emergency remains in effect, DEA-registered practitioners may issue prescriptions for controlled substances to patients for whom they have not conducted an in-person medical evaluation, provided all of the following conditions are met:
- The prescription is issued for a legitimate medical purpose by a practitioner acting in the usual course of his/her professional practice
- The telemedicine communication is conducted using an audio-visual, real-time, two-way interactive communication system.
- The practitioner is acting in accordance with applicable Federal and State law.

CMS

- PHE application
- ***Effective for services starting March 6, 2020 and for the duration of the COVID-19 Public Health Emergency, Medicare will make payment for Medicare telehealth services furnished to patients in broader circumstances.***
- ***These visits are considered the same as in-person visits and are paid at the same rate as regular, in-person visits.***

CMS Continued

- ***Starting March 6, 2020 and for the duration of the COVID-19 Public Health Emergency, Medicare will make payment for professional services furnished to beneficiaries in all areas of the country in all settings.***
- ***While they must generally travel to or be located in certain types of originating sites such as a physician's office, skilled nursing facility or hospital for the visit, effective for services starting March 6, 2020 and for the duration of the COVID-19 Public Health Emergency, Medicare will make payment for Medicare telehealth services furnished to beneficiaries in any healthcare facility and in their home.***

CMS Continued

- ***The Medicare coinsurance and deductible would generally apply to these services. However, the HHS Office of Inspector General (OIG) is providing flexibility for healthcare providers to reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs.***
- ***To the extent the 1135 waiver requires an established relationship, HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency.***

CMS Fact Sheet with FAQs

- 150 pages
- Updated 11/12/20
- Email me for a copy

Liability concerns

- Med Mal coverage
- Informed consent documentation
- Traveling patients

Additional Information

- For more information, please
- Email questions, concerns, or comments to
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