

# Compliance Guidance: Physician EMR Documentation~ Evaluation and Management Services Advisory

## Background

The quality of care provide to a patient is firmly based in the clinical documentation in the medical record. Government agencies such as the Office of Inspector General (OIG), Centers for Medicare & Medicaid Services (CMS), our MAC-Noridian Healthcare Solutions (Noridian) and leading organizations such as the Association of American Medical Colleges have published documentation guidelines to assist physicians with documentation issues. The advisory will pinpoint critical evaluation and management (E&M) documentation issues as well as provide some best practices.

## EMR Documentation

In order for an accurate E&M level of service to be determined, the medical record documentation for any individual date of service must contain:

1. A chief complaint, documented by the physician, which is clear and individualized about the particular patient's reason for the visit,
2. A patient-specific and relevant history and exam and;
3. A plan of care that relates to the chief complaint

The OIG and Noridian caution that documentation inaccuracies and overdocumentation practices have the potential to question the medical necessity of the service billed which may affect reimbursement and expose the organization to risk. **Avoid** using any of the following risky documentation practices:

⇒ Generalized chief complaint statements such as "lab results" or "follow up".

- ✓ The chief complaint is a required history component for every E&M service; it is the reason the patient came into the office or clinic for a visit on that particular day. CMS defines chief complaint as "a concise statement describing the symptom, problem, condition, diagnosis, and physician recommended return, or other factor that is the reason for the encounter." Here are examples of a valid chief complaint for a patient visit regarding test results:

- *"Follow-up for hyperlipidemia"*
- *"The patient is here for test results following a hemoglobin A1c for diabetes"*

When specific statements such as these are documented, the underlying condition is identified and the chief complaint is acceptable.

⇒ Identical patient history or exam documentation used from patient to patient.

- ✓ **Do not** use generalized or auto-populated statements within evaluation and management documentation if it does not support the individual patient's clinical management. Documentation that contains cloned, identical statements from patient to patient with no evidence of clinical relevance can be perceived as fraudulent when reviewed by a third party. Such documentation does not demonstrate quality patient care and may result in payment denial.

⇒ Generalized Past, Family, Social history (PFSH) statement or Review of System (ROS) statements used from patient to patient.

- ✓ The PFSH and ROS are part of the history documentation. The nature of the presenting problem(s) indicates the need to perform and document a PFSH and/or a ROS. To receive credit for those elements, they must be related to the patient's problem(s) documented in the history for that date of service. Noridian requires PFSH documentation to be "pertinent to the date of service in question and applicable to the medical management of that particular patient on that particular day".

⇒ Electronically signing documentation containing nonsensical or grammatical errors.

- ✓ **Do not** sign clinical documentation that contains grammatical errors, nonsensical statements or incomplete information. Your electronic signature is a confirmation that the medical record note is accurate, complete and free of omissions. Noridian encourages providers to proofread all documentation prior to signing the note to avoid potential payment denials.

### Conclusion

The integrity of the medical record documentation is essential to appropriate reimbursement for E&M services. Unedited copy-pasting or standard template phrases used from patient to patient, conflicting documentation, as well as unchecked inaccuracies and grammatical errors reduce the documentation quality and are considered unacceptable by UCDHS Compliance.

This advisory has outlined documentation guidance from leading official sources and provided best practices for providers to incorporate when using the EMR to document E&M services. Providers are encouraged to utilize these best practices to structure their documentation routine. The CMS E&M Documentation Guidelines remind us that "*Clear and concise medical record documentation is critical to providing patients with quality care and is required in order for providers to receive accurate and timely payment for furnished services*".

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Thank you for taking the time to review the information in this advisory.  
If there are any questions, please contact:

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