# The Medicare Documentation System

## NGS J6 Transition

- I was recently informed by a friend that he received a letter from an Electronic Data Interchange (EDI) company that they were the EDI gateway for NGS and he needed to sign up right away.
- This may be true or it may be a company trying to take advantage of your lack of knowledge.
- Before you sign up I would suggest that you get the facts.
- NGS will be hosting a series of free webinars in May and June regarding EDI.
- The dates and registration information are in your notes.
- Keep in mind that during this transition there will likely be some opportunists trying to take advantage of the situation.
- Contact NGS and confirm that things are really as you are told they are.

**J6 EDI Early Boarding Webinars**
**Available for Registration**

The Centers for Medicare & Medicaid Services (CMS) selected National Government Services as the new Medicare Administrative Contractor (MAC) for Part A/Part B Jurisdiction 6 (J6). The J6 service area includes Part A and Part B providers in the states of Illinois, Minnesota, and Wisconsin, and National Government Services current HH+H and Federally Qualified Health Center (FQHC) providers. National Government Services will assume responsibility for J6 A/B MAC workload in segments based on geographic location/outgoing contractor.

Part A and Part B providers who will be submitting Electronic Data Interchange (EDI) claims to the J6 MAC are being offered an early boarding opportunity to facilitate their transition to the National Government Services EDI Gateway! Early boarding is a term that refers to a process that allows submitters to establish connectivity to and submit claims through the National Government Services EDI Gateway and to receive remittances through the National Government Services EDI Mailbox prior to cutover to the J6 MAC.

To learn more about how your facility can participate in this early boarding opportunity, please register for a Webinar to learn about: connectivity with the National Government Services EDI Gateway, early boarding opportunities/processes, EDI Enrollment, and EDI Help Desk.

Webinars will be held on the following dates and times:

Monday, May 20, 2013
9:00 - 11:00 a.m. central time (CT)
10:00 a.m. - 12:00 p.m. eastern time (ET)

Thursday, June 13, 2013

9:00 - 11:00 a.m. CT
10:00 a.m. - 12:00 p.m. ET

Thursday, June 20, 2013
1:00 - 3:00 p.m. CT
2:00 - 4:00 p.m. ET

Thursday, June 27, 2013
1:00 - 3:00 p.m. CT
2:00 - 4:00 p.m. ET

**Registration:**
Visit our Web site for registration details at http://www.ngsmedicare.com. Select Part A or Part B, and then select the Training Events Calendar option under the Education and Training category (on the left-hand side). Select the date of the session you wish to attend and complete the registration. Please note that a separate registration should be completed for each person who plans to attend as the Webinar details are unique to each attendee. Your registration is complete only when you receive a confirmation at your e-mail address immediately after submitting your registration.

# Medicare Documentation System

- Medicare requires that you collect specific data from the patient at what they classify as the initial visit and the subsequent visits.
- Though the terms are different these requirements easily fit into the Assessment visit/Treatment visit model.
- The Assessment visit is when we assess the patient's condition and develop a treatment plan.
- Assessment visits occur at the initial visit to establish the baseline condition of the patient and every 30 days thereafter to monitor the change in the patient's condition.
- Treatment visits occur between Assessment visits.
- Treatment visits are where we implement the treatment plan developed during the Assessment visit.
- The documentation burden is different for the Assessment visit than it is for that Treatment visit.
- The Medicare Documentation System is the first system specifically designed to work with the Assessment Visit/Treatment Visit model.
- This model should become the standard within the profession for chiropractic documentation as this model best describes what we do and how we do it.
- When third party payers recognize this model we will get fewer rejections.
- The Medicare Documentation System is designed to accomplish three things.
    - Gather the Medicare required information from the patient using patient friendly language.

    - Provide you with the tools necessary to best utilize this information in the medical decision making process.
    - Report this information to Medicare using terms that the reviewers understand.
- The first information that you have to gather is the patient's contact information and the primary and secondary insurance information.
- Since we are dealing with Medicare, you also have to make a reasonable effort to determine if that patient has insurance that is primary to Medicare.
- The following form is designed to do just that.
- The top part of this form will collect the patient information as required by NCQA.
- The middle section contains five yes or no questions to determine if the patient has insurance that Medicare would be secondary to.
- The bottom section collects information regarding the patient's secondary insurance.
- This one form contains the majority of the Protected Health Information (PHI)
- Initial Visit Required Documentation
    - History
    - Description of the present illness
    - Evaluation of musculoskeletal/nervous system through physical examination
    - Diagnosis
    - Treatment plan
    - Date of initial treatment
- The history recorded in the patient record should include the following:
    - Symptoms causing patient to seek treatment;
    - Family history if relevant;
    - Past health history (general health, prior illness, injuries or hospitalizations; medications; surgical history);
    - Mechanism of trauma;
    - Quality and character of symptoms/problem;
    - Onset, duration, intensity, frequency, location and radiation of symptoms;
    - Aggravating or relieving factors; and
    - Prior interventions, treatments, medications, secondary complaints.
    - Social History (not required but advisable)
- The first page focuses on the Chief Compliant and the secondary complaint.
- It also includes the patient's allergies which are not required by Medicare but are required by NCQA and for meaningful use.
- The second page covers family history and past history.
- It also includes social history and medications.
- Neither are required by Medicare but both are required by NCQA and meaningful use.
- The next required element is a Description of the Present Illness.
- This is a repeat of many of the elements from the History.

- The only logical reason that they would repeat required information is that they want the doctor to directly review this information with the patient.
- With that in mind I developed a Consultation Form.
- The Consultation Form will take you through each element that needs to be reviewed with the patient.
- The next element is Evaluation of musculoskeletal/nervous system through physical examination.
- Usually each doctor has his or her own protocols for exams.
- For this reason I did not include an exam form.
- There is information regarding Outcomes Assessment Questionnaires and copies of the Revised Oswestry and Neck Disability forms.
- Diagnosis is the next required element.
- There is information regarding diagnosis in the manual as well as links to find your Local Coverage Determination.
- This will provide you with diagnosis information that applies to you as each jurisdiction is different.
- The next required element is the Treatment Plan.
- Medicare requires three items in a treatment plan.
    - Recommended level of care (duration and frequency of visits);
    - Specific treatment goals;
    - Objective measures to evaluate treatment effectiveness.
- The checklist treatment plan form is designed to match the outcome assessment questionnaire.
- At the top are the long term goals.
- You check number that matches the section that the patient selected.
- For the short term goals you check the letter that matches the letter that the patient selected in that section.
- A staff member can then input this information into the EHR.
- The system also includes a template for a narrative treatment plan.
- This should be utilized when there is a records request.
- A staff member should be able to complete this from the checklist treatment plan in the file.
- The system includes information on how to determine the correct Initial Date of Treatment.
- There is also a webinar on how to properly complete and use the Advance Beneficiary Notice of non-coverage (ABN) as well as the latest version of the ABN in Word format.
- There is also a patient education handout explaining how Medicare works with chiropractic.
- Medicare also requires specific items for the treatment visit or what they call the subsequent visit.
- They require:
    - History.
    - Physical Exam.
    - Documentation of treatment given on day of visit.

- This sounds complicated but it really isn't.
- For the history they require three elements:
    - Review of chief complaint.
    - Changes since last visit.
    - Systems review if relevant.
- For the physical exam they require:
    - Exam of area of spine involved in diagnosis.
    - Assessment of change in patient condition since last visit.
    - Evaluation of treatment effectiveness.
- The documentation of treatment given on day of visit is essentially a stand alone element.
- The treatment visit note form is designed to capture this information.
- The top of the form captures that patient's name, the date of the treatment, the date of initial treatment, and the scheduled date of the re-exam.
- The History section captures the review of chief complaint and the changes since last visit.
- If a system review is relevant you will use and exam form for that.
- The Physical Exam section uses PART.
- Each element of PART is noted using the appropriate shorthand in the appropriate column.
- There are areas for additional comments on each element.
- There is a column to note the treatment given and an area to note the changes in patient's condition.
- You can note the technique used, appropriate therapy information, next visit, and any comments for that visit.
- When properly completed by the doctor, this form conveys all pertinent information regarding this visit to the staff.
- The staff can use this to enter the information into the EHR.
- The assessment visit is not limited to the initial visit.
- You should re-assess the patient's condition every 30 days to determine if they are making significant progress and if further care is indicated.
- It is important that this be done on a regular basis because it indicates to third-party payers that you are monitoring the patient's condition and are responsive to changes in their condition.
- The re-exam should include:
    - A history update.
    - An exam including a retest of all positive and significantly negative orthopedic and neurological tests.
    - The re-administration of the outcome assessment questionnaire(s).
    - A new treatment plan.
    - Changes in diagnoses if indicated.
- The History Update Form is designed to capture information about the current status of the primary and secondary complaints.
- There is also space for information regarding a new problem.

- There is no need to repeat information regarding the family history, past history, or social history as these are unlikely to change in any significant way.
- Collecting the required information is only half of the job.
- You need to report this information to Medicare reviewers in a format that they understand.
- When Medicare requests records it is for what they term a Complex Medical Review.
- A Complex Medical Review is performed by a licensed professional.
- The minimum level of licensure is a Registered Nurse.
- An RN knows medical documentation well.
- The problem is that most RNs only know what they have read in the Medicare manuals about chiropractic.
- To effectively communicate what you have done to and for the patient, you must use familiar terms.
- The Assessment Visit Report is a summary of the information obtained during the assessment visit.
- You can indicate if this is an initial visit of one of the re-exams.
- All terms used are taken from the Medicare manuals.
- Page 2 of the form covers the exam, including PART, the outcome assessment questionnaire results, and diagnoses.
- There are 5 spots for primary and secondary diagnoses.
- There is also a Treatment Visit Report Form for reporting summaries of the treatment visits between two adjacent assessment visits.
- The Treatment Visit Report Form can handle up to 14 treatment visits.
- You simply print sufficient pages to cover the number of visits that actually occurred.
- The Treatment Visit Report has a section at the top that summarizes the patient's primary and secondary complaints and the changes in the outcome assessment questionnaire(s).
- There is also an indication of whether the patient followed the treatment plan.
- Each visit then has a summary that includes all of the required information and information regarding PART.
- The report forms are designed to be completed by the staff using the information collected on the other forms.
- They are to be completed when Medicare requests notes on a visit for review.
- You should include the assessment visit before and after the date in question and all treatment visits between the assessment visits.
- The system includes a cover letter template for a records request that will explain the included documentation.
- There is also a complete sample documentation package in the appendix showing how a response to a records should look.
- The Medicare Documentation System is designed to optimize the doctor's time by using forms to capture Medicare required information in the most efficient manner possible.

- The staff can then utilize this information to correctly bill for services and, if necessary, prepare reports in response to records requests.
- This system will work with any EHR system by staff inputting the appropriate information from the forms into the computer based program.