Policy Statement:
Sentara Medical Group (SMG) is committed to timely and accurate documentation, coding and billing for all services. SMG is proactive in assuring the accuracy of the medical claim billing with physician and employee education, tracking visit encounter completion, as well as random chart audits to ensure compliance.

Exceptions:
No exceptions.

Procedure:

Coding the EMR Encounter:
The physician, nurse practitioner, physician assistant, or other clinical staff rendering services to the patient is responsible for accurately completing the visit encounter, which includes the order entry, documentation, charge capture, etc. The documentation in the Epic electronic medical record will support the services the provider indicated.

Closing the Visit Encounter:
The visit encounter should remain open until all of the required elements for documentation have been completed. Closing the visit encounter within the electronic medical record will produce the charges and file a claim to the insurance company.

Timeliness of Documentation and Closing the Visit Encounter:
Documentation should ideally occur in real time immediately after completion of a visit. Visit encounters should be completed and closed within five (5) calendar days of the visit. In our current practice environment supported by the EMR, it has become the expectation of providers and patients to be able to see the episode when they go to the next venue of care (i.e. emergency room or other physician office). Near real time availability of information is an expectation of quality care.

Concise medical record documentation is critical to providing quality medical care, supporting the services provided and receiving timely reimbursement. If it is not submitted or is incomplete at the time it is received in the billing department, then it is difficult to support the services being billed. The medical record documentation should chronologically document the care of the patient and is required to record clinically pertinent facts, findings and observations about the patient’s health history, which may include past and present illnesses, examinations, tests, treatments and outcomes. It also assists other physicians and health care practitioners in evaluating and planning the patient’s treatment and monitoring of care.

ICD-9 Coding:
The following principles will help to ensure that the diagnosis codes selected will accurately demonstrate the patient’s condition as well as the medical necessity for the visit.

The reason the patient came for treatment should be the primary diagnosis. All other procedures, labs, x-rays, medications, etc. require linkage to the reason the patient is having the additional services. The ICD-9 code needs to be coded to the highest level of specificity.

“Rule-out” or “suspected” conditions should not be coded.
Symptoms should only be coded if no definite diagnosis is determined at the time of the visit.
Chronic complaints should only be coded when treatment is relevant to the visit.
CPT Coding:
CPT is a systematic listing of codes for medical procedures and services. The provider selects the CPT that accurately identifies the services performed. The provider is responsible for, but not limited to, ensuring the following:

- Appropriate linkage of ICD-9 codes to each service charged.
- Correct use of modifiers.
- The use of units, especially with surgical procedures, allergy injections, medications, etc.
- Avoid inappropriate unbundling of codes, i.e. charging for local anesthesia with simple repairs, etc.
- Correct billing for workers’ compensation/occupational medicine/accidents (i.e. motor vehicle accidents).

HCPCS Coding:
These codes have an alpha prefix and provide a uniform method of reporting medical supplies, professional services, medications and procedures, thus curtailing the use of non-specific codes.

Updates, Additions, Deletions and Other Changes:
Notification of additions, changes or deletions of ICD-9, CPT and HCPCS codes are supplied to all providers and managers to review and utilize within their realm of specialty. New resource books or materials are purchased yearly and supplied to all staff for reference to ensure compliance.

Remedies for Unclosed Visit Encounters:
Because of the implications for patient safety and care coordination, as well as potential delay in reimbursement, every physician, non-physician practitioner and employee utilizing the electronic medical record has an obligation to accurately complete and close out visit encounters. This includes the body of the encounter and any related messages, test results, consultation reports or other documents related to the visit encounter. There will be little tolerance for habitual offenders in not meeting the guidelines for completion of the record and closure of the visit encounter.

Regardless of the absolute number of records involved, a formal warning will be issued to any physician who is delinquent in closing visit encounters (defined as greater than seven (7) calendar days from the date of service). The warning notice generated on day eight (8) will give the delinquent physician seven (7) consecutive calendar days to remedy the situation. If the physician continues to have unclosed visit encounters fourteen (14) days from the date of service, a second notice will be generated on day fifteen (15), which will notify the physician that they will be suspended without pay if the physician continues to have unclosed visit encounters twenty-one (21) days from the date of service. If the physician continues to have unclosed visit encounters twenty-one (21) days from the date of service, a third notice will be generated on day twenty-two (22), which will notify the physician that they suspended without pay. The suspension without pay will continue until all delinquent visit encounters (defined as greater than seven (7) calendar days from the date of service) have been closed. After that time, any future episodes of delinquency will be reported to the SMG Board’s Audit and Compliance Committee for their review and determination of further disciplinary action. All warning notices will be hand delivered to the providers, and the providers will be asked to sign a document confirming they are in receipt of the notice.

Non-physician practitioners will be held to the same remedies as mentioned in the preceding paragraph.

It has been agreed that the SMG Board empowers the SMG Executive Management Team, in collaboration with the SMG Board Executive Committee, to revise the mechanics of the administration of this process, as necessary.

Monitoring:

Outcomes Monitoring – The SMG Board empowers the SMG Executive Management Team, in collaboration with the SMG Board Executive Committee, to revise the mechanics of the administration of this process, as necessary.

Document Management – SMG Administration shall be responsible for developing, communicating and maintaining this policy and related procedures and job aids necessary for the implementation and continuance of the policy. This policy shall be reviewed at least every 1 year for repeal or amendment as appropriate.
Frequently Asked Questions:

1. Do I have to leave the visit encounter open until all ordered lab results return?
   No, the results will file to your In Basket as they are resulted and you can view the encounter summary to determine necessary action and create a QUICK NOTE from the result that will file to the original progress note, if needed.

2. Do I have to leave the visit encounter open if I performed a skin biopsy while I await the diagnosis of the lesion removal?
   Some sites (dermatology most often) are doing this to code the appropriate level of service and diagnosis for that particular patient.

3. What is the difference between an OPEN ENCOUNTER and an OPEN CHART (i.e. visit encounter) in my In Basket?
   An open encounter can be any refill or telephone encounter that you have created and is not yet complete. An open chart means that you have a visit encounter that needs to be completed and closed. What makes the visit encounter close?
   The only way to close a visit encounter is to be in the encounter and click on the close encounter link on the visit navigator - X’ing out of the chart does not close the visit encounter.

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5. If I close the visit encounter and need to enter additional documentation, how do I accomplish that?
   You would need to create an addendum. If you are on the schedule for which you need to create an addendum, you can just double click on the name and reopen the encounter. If the schedule date has passed, you can: go to the “Patient Care” link on the main menu; select from the drop down menu “Addendum;” input your patient’s name in the look up box; and select the encounter that needs the addendum. Double click on the encounter date and it will open the addendum to add your documentation.

6. What is the urgency for closing the visit encounter?
   In an electronic world, the expectation is that clinical information be available as soon as the patient is seen.
   In addition, prompt availability of clinical information is increasingly becoming an indicator of a quality medical practice.
   This is the only way that your charges will be sent to the interface engine for processing to the insurance carrier.
   The visit encounter should remain open until all of the required elements for documentation have been completed.

7. I like to leave the office visit encounter open to remind me to call a patient and check on their meds.
   This can be done through a personal reminder staff message. You can send yourself a message to call a patient and set it up to send to your In Basket on a certain day. You can also attach the patient's chart to that message so that you can review the chart easily.

8. I like to leave the visit encounter open so that I can update the Health Maintenance items on my down time.
   You can update the Health Maintenance through the appointment desk or the snapshot from the schedule. You do not have to be within a visit encounter to update this information.

Related Documents:

Procedures
Regulatory References