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NEW ENGLAND HEALTHCARE INTERNAL AUDITORS INC.

HFMA/NEHIA
2022 Compliance & Internal Audit Conference

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Mystic Marriott Hotel, Groton, CT

2023 Coding Updates: Making Sense of the Madness

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Disclaimer

Although every reasonable effort has been made to assure the accuracy of the information within these pages at the time of publication, the Medicare program is constantly changing, and it is the responsibility of each provider to remain abreast of the Medicare program requirements. Any regulations, policies and/or guidelines cited in this publication are subject to change without further notice. Current Medicare regulations can be found on the Center for Medicare and Medicaid Services (CMS) website at www.cms.hhs.gov.

CPT Disclaimer

Learning Objectives

- 2023 CMS and AMA Changes
- E/M Guidelines Changes Overview
  - Medical Decision-Making
  - Time-Based Billing Requirements
- 2023 Final Rule Updates
  - Shared/Split E/M Services
  - Telehealth Services
  - Chronic Pain Management
  - Audiology
- 2023 Compliance Strategies

2023 AMA CPT Code Changes by Chapter

Chapter	Additions	Revisions	Deletions
Evaluation and management	1	49	25
Integumentary system	3	1	1
Musculoskeletal system	1	2	0
Respiratory system	1	0	0
Cardiovascular system	7	1	0
Digestive system	17	0	18
Urinary system	1	1	0
Male genital system	1	0	0
Nervous system	0	7	0
Eye and ocular adnexa	0	2	0
Auditory system	3	5	0
Radiology	1	5	0
Pathology and laboratory	82	7	7
Medicine	38	9	0
Category III	68	3	23
Administrative multianalyte assays with algorithmic analyses	0	1	0
TOTAL	**224**	**93**	**74**

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Why The Need For Change?

- To decrease administrative burden of documentation and coding, and align CPT and CMS whenever possible
- To decrease unnecessary documentation in the medical record that is not needed for patient care
- To ensure that payment for E/M is resource-based and that there is no direct goal for payment redistribution between specialties

Overview of 2023 E/M Changes

Inpatient and Observation Care Services

- **Deletion** of observation services (**99217-99220 and 99224-99226**) and merged them into the existing hospital care services (**99221-99223, 99231-99233, 99234-99236, 99238-99239**)
- **Revision** of the code descriptors to account for the structure of total time on the date of the encounter or level of MDM when selecting code level

Consultations

- **Deletion** of **99241 and 99251**
- **Retention** of the consultation codes, with some editorial revision to the code descriptors

Emergency Department Services

- **Retention** of existing codes (**99281-99285**)
- **Retention** of the existing principle that **time cannot be used as a key criterion** for code level selection
- Revisions to the code descriptors

Nursing Facility Services

- **Deletion** of annual nursing facility assessment (**99318**)
- **Retention** of existing codes (**99304-99306, 99307-99310**)
- **Revision** of the code descriptors to account for the structure of total time on the date of the encounter or level of MDM when selecting code level

Home and Residence Services

- **Deletion** of the domiciliary/rest home services (**99334-99340**) and **merged** them with existing home visit CPT codes (**99341-99350**)
- **Elimination** of the duplicate MDM Level New Patient code (**99343**)

Prolonged Services

- **Deletion** of direct patient contact prolonged service codes (**99354-99357**), reported through 2021 office prolonged service code (**99417**), or the new inpatient/observation/nursing facility service code (**993X0**)
- **Retention of 99358-99359** for use on dates other than the date of any reported 'total time on the date of the encounter" service

2023 Updates

Evaluation and Management (E/M Services)

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Medical Necessity

- The American Medical Association (AMA) policy H-320.953[3] defines medical necessity as:

> Health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease or its symptoms in a manner that is: (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate in terms of type, frequency, extent, site and duration; and (c) not primarily for the convenience of the patient, physician, or other health care provider.

- Medical necessity 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 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

General Principles of Medical Record Documentation

- The medical record should be complete and legible
- The documentation of each patient encounter should include:
  - Reason for the encounter and relevant history, physical examination findings, and prior diagnostic test results
  - Assessment, clinical impression, or diagnosis
  - Medical plan of care
- If the rationale for ordering diagnostic and other ancillary services is not documented, it should be easily inferred
- Appropriate health risk factors should be identified
- The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented
- The diagnosis and treatment codes reported on the health insurance claim form or billing statement should be supported by documentation in the medical record
- The provider must ensure that medical record documentation supports the level of service reported to a payer

Updated Classification

New vs Established Patients

- **New Patient:** An individual who has not received any professional services from the physician/advanced practice provider (APP) or another physician of the **exact same specialty and subspecialty** who belongs to the same group practice within the **previous 3 years**
- **Established Patient:** An individual who has received professional services from the physician/APP or another physician of the **exact same specialty and subspecialty** who belongs to the same group practice within the previous 3 years

NOTE: For Emergency Department Services, there is no distinction made between new and established patients. All patients are considered to be new to the Emergency Department

Initial vs Subsequent Patients

A new section has been added titled initial and subsequent services which will apply to hospital inpatient, observation care, and nursing facility CPT codes

- **Initial:** A patient who has **not received** any professional services from the physician/APP or another physician/APP of the **exact same specialty and subspecialty** who belongs to the same group practice, during the inpatient, observation, or nursing facility admission and stay
- **Subsequent:** A patient who **has received** professional services from the physician/APP or another physician/APP of the **exact same specialty and subspecialty** who belongs to the same group practice, during the admission and stay

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Changes in CPT Guidelines

When the patient is admitted to the hospital as an inpatient or to observation status in the course of an encounter in another site of service (e.g., hospital emergency department, office), **the services in the initial site may be separately reported**. Modifier 25 may be added to the other evaluation and management service to indicate a significant, separately identifiable service by the same physician or other qualified health care professional was performed on the same date.

Emergency Department Services

- **Emergency Department** – an organized hospital-based facility for the provision of unscheduled episodic services to patients who present for immediate medical attention.
- The facility must be available 24 hours a day
- No distinction is made between new and established patients in the emergency department. *(No change made to this in 2023).*
- Selection of the CPT code will solely be based on **medical decision-making.** Time is **NOT** a factor in emergency department encounters.
- Change to CPT Code 99281
- For critical care services provided in the emergency department, see Critical Care guidelines and 99291, 99292. Critical care and emergency department services may both be reported on the same day when after completion of the emergency department service, the condition of the patient changes, and critical care services are provided

Documentation Recommendations

Build the “diagnostic story” through documentation of:

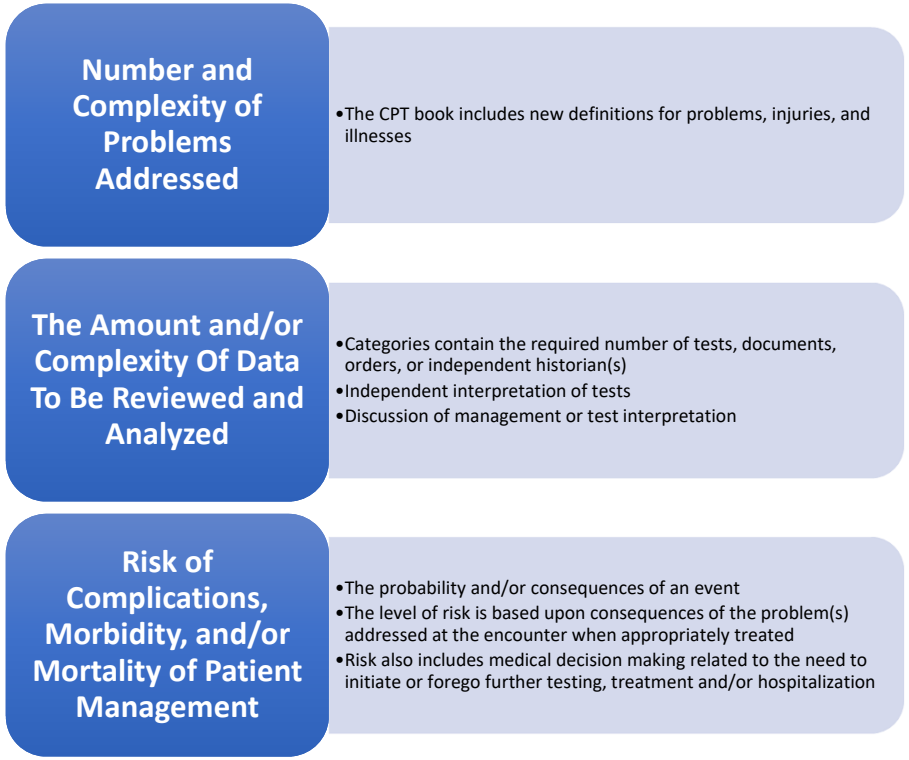
- A comprehensive Assessment and Plan (A&P)
- Link etiologies of signs/symptoms/conditions, cause-and-effect relationships, and manifestations of disease processes to the presenting problem(s), when appropriate
- Responses to treatments, study results (when available), or changes in clinical condition(s)
- The patient’s progress, efficacy of and/or change in treatment, and revision of diagnoses should be documented
- Differential Diagnosis(s): Terms such as “suspected”, “possible” and “probable” for unconfirmed diagnoses that are consistent with clinical indicators, work-up and treatment plan **help support complexity of the patient and risk**
- Medically appropriate history and exam to support the level of medical decision-making

History and Exam

- Effective January 1, 2023, history and physical exam are no longer elements used in selection of Evaluation and Management services (E/M).
- E/M visits should include a medically appropriate history and exam.
- These services should still be documented in the patient's medical record.
  - The nature and extent of the history and/or physical examination are determined by the treating physician or other qualified health care professional reporting the service.
  - The care team may collect information, and the patient or caregiver may supply information directly (e.g., by electronic health record [EHR] portal or questionnaire) that is reviewed by the reporting physician or other qualified health care professional.

2023 Medical Decision-Making (MDM)

- Four levels of MDM:
  - Straightforward
  - Low
  - Moderate
  - High



To qualify for a particular E/M level of MDM, two of the three elements for that level of MDM must be met or exceed.

Table 2 – CPT E/M Office Revisions
Level of Medical Decision Making (MDM)

Revisions effective January 1, 2023: 2021 E/M Grid updated yellow highlights for 2023.

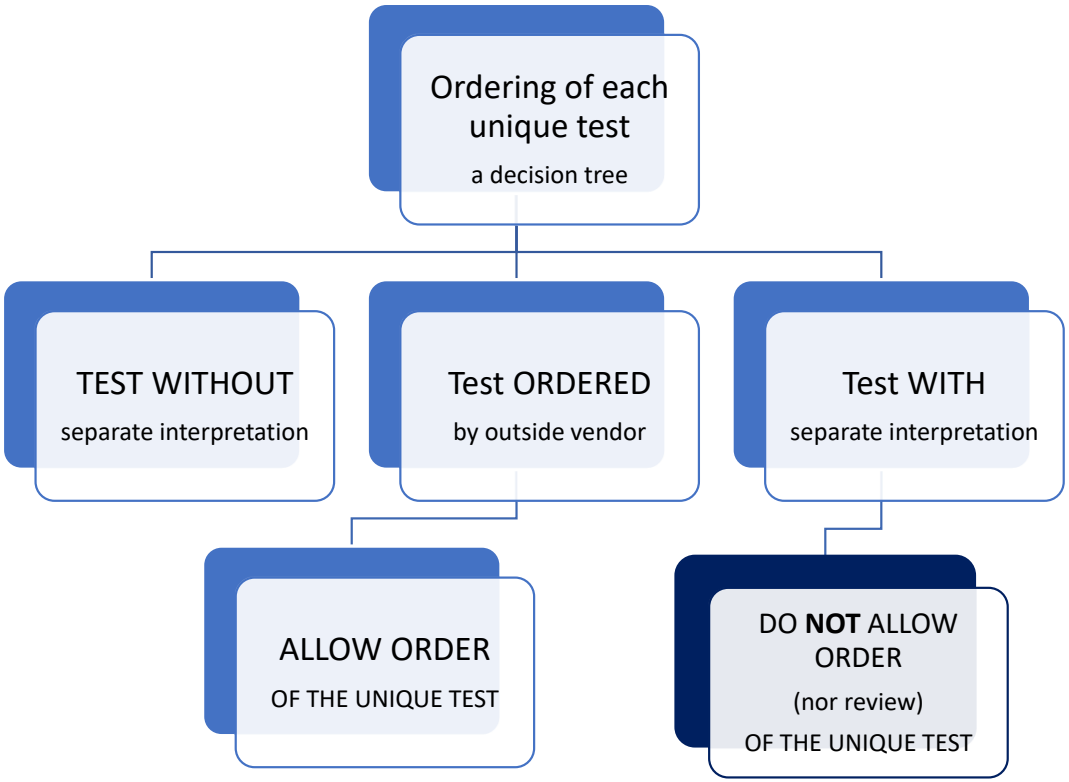
	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making: Number and Complexity of Problems Addressed	Elements of Medical Decision Making: Amount and/or Complexity of Data to be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	Elements of Medical Decision Making: Risk of Complications and/or Morbidity or Mortality of Patient Management
	N/A	N/A	N/A	N/A
	Straightforward	**Minimal** • **1** self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**

	Low	**Low**
		• **2** or more self-limited or rminor problems;
		or
		• **1** stable chronic illness;
		or
		• **1 acute uncomplicated illness or injury;**
		or ***1 stable acute illness***
		or ***1 acute uncomplicated illness or injury requiring hospital inpatient or observation level of care.***
			Limited
			(Must meet the requirements of at least 1 of the 2 categories)
			Category 1: Tests and documents
			• **Any combination of 2 from the following:**
			  • Review of prior external note(s) from each unique source*;
			  • review of the result(s) of each unique test*;
			  • ordering of each unique test*
			or
			Category 2: Assessment requiring an independent historian(s)
			(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)
				Low risk of morbidity from additional diagnostic testing or treatment

	Moderate	**Moderate**
		• **1** or more chronic illnesses with exacerbation, progression, or side effects of treatment;
		or
		• **2** or more stable chronic illnesses;
		or
		• **1** undiagnosed new problem with uncertain prognosis;
		or
		• **1** acute illness with systemic symptoms;
		or
		• **1** acute complicated injury
			Moderate
			(Must meet the requirements of at least 1 out of 3 categories)
			Category 1: Tests, documents, or independent historian(s)
			• **Any combination of 3 from the following:**
			  • Review of prior external note(s) from each unique source*;
			  • Review of the result(s) of each unique test*;
			  • Ordering of each unique test*;
			  • Assessment requiring an independent historian(s)
			or
			Category 2: Independent interpretation of tests
			• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
			or
			Category 3: Discussion of management or test interpretation
			• Discussion of management or test interpretation with external physician/other qualified health care professional\appropriate source (not separately reported)
				Moderate risk of morbidity from additional diagnostic testing or treatment
				
				Examples only:
				• Prescription drug management
				• Decision regarding minor surgery with identified patient or procedure risk factors
				• Decision regarding elective major surgery without identified patient or procedure risk factors
				• Diagnosis or treatment significantly limited by social determinants of health

	High	**High**
		• **1** or more chronic illnesses with severe exacerbation, progression, or side effects of treatment;
		or
		• **1** acute or chronic illness or injury that poses a threat to life or bodily function
			Extensive
			(Must meet the requirements of at least 2 out of 3 categories)
			
			Category 1: Tests, documents, or independent historian(s)
			• **Any combination of 3 from the following:**
			  • Review of prior external note(s) from each unique source*;
			  • Review of the result(s) of each unique test*;
			  • Ordering of each unique test*;
			  • Assessment requiring an independent historian(s)
			or
			Category 2: Independent interpretation of tests
			• **Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);**
			or
			Category 3: Discussion of management or test interpretation
			• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
				High risk of morbidity from additional diagnostic testing or treatment
				
				Examples only:
				• Drug therapy requiring intensive monitoring for toxicity
				• Decision regarding elective major surgery with identified patient or procedure risk factors
				• Decision regarding emergency major surgery
				• Decision regarding hospitalization ***or escalation of hospital-level care.***
				• Decision not to resuscitate or de-escalate because of poor prognosis.
				• ***Parenteral controlled substances.***

2023 Clarifications for E/M and Separately Reported Services



Problems Addressed at the Encounter Definitions

Problem: A problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other matter addressed at the encounter, **with or without a diagnosis being established at the time of the encounter**

Problem addressed: A problem is addressed or managed when it is evaluated or treated at the encounter by the physician or other qualified health care professional reporting the service. **For hospital inpatient and observation care services, the problem addressed is the problem status on the date of the encounter, which may be significantly different than on admission. It is the problem being managed or co-managed by the reporting physician or other qualified health care professional and may not be the cause of admission or continued stay**

Time

- Total time on the **date of the encounter** includes:
  - Face-to-face time
  - Non-face-to-face time
  - Time personally spent by the physician and/or other qualified health care professional(s) on the day of the encounter
- Time does **not** include time:
  - Activities normally performed by non-clinical/ancillary staff and scribes
  - Time spent by a resident/fellow may only be counted in a Primary Care Exception setting
  - *The performance of other services that are reported separately**
  - *Travel**
  - *Teaching that is general and not limited to discussion that is required for the management of a specific patient**

Sample Statement: "Total clinical time spent by me (MD or APP) on date of this encounter is *** minutes including preparing to see the patient, obtaining history, performing examination, *** and documenting clinical information in this electronic medical record."

Physician/APP time includes the following activities, when performed:

- Preparing to see the patient (e.g., review of tests)
- Obtaining and/or reviewing separately obtained history
- Performing a medically appropriate examination and/or evaluation
- Counseling and educating the patient/family/caregiver
- Ordering medications, tests, or procedures
- Referring and communicating with other health care professionals (when not separately reported)
- Documenting clinical information in the electronic or other health record
- Independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
- Care coordination (not separately reported)

2023 Updates

Shared/Split Services, Telehealth Services, Chronic Pain Management, and Audiology Services

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CMS Shared/Split Updates

A split/shared service is an encounter where a physician and an APP each personally perform a portion of an E/M visit

- Split/shared visits could be reported for both ***new*** **and established** patients and ***initial*** **and subsequent** patients; and Critical Care services can now be split/shared services
- May be provided in a ***facility setting by a physician and an APP who must be a part of the same (billing) group practice:***
  - Faculty group practice employed physician and NPP – **YES**
  - Faculty Group Practice physician and Hospital employed NPP – **NO**
- Documentation must support the **combined service level** reported on the claim
- Only **one** of the practitioners **must** have face-to-face (in-person) contact with the patient
- Each physician/NPP should **personally document** in the medical record his/her portion of the visit
- The physician and NPP services must take place on same date of service
- **Modifier FS** is required to be appended to E/M level for split/shared visits

To bill under the physician's NPI:

- Physician **must perform one** of the key components in **its entirety**
- Physician **does not need** to document any of the other two key components.

The split/shared guidelines do not apply to procedures.

CMS Shared/Split Visit Guidelines – Substantive Portion

- For the physician to bill a split/shared visit, the physician must perform a **substantive portion** of the encounter in order to be the billing provider, but documentation must identify **both** providers
- Substantive portion has been newly defined by CMS as:
  - History, **OR** Physical Exam, **OR** Medical Decision-Making (at **least 1 of 3 it's entirety**); Or
  - **More than half (>50%)** of the total time of the visit.
- The Physician's addendum to NPP's note must clearly document that he/she **personally performed** a **substantive portion** of the service in order to bill under the physician's name and NPI at 100%
  - e.g., Medical Decision-Making
- The billing provider **must sign and date** the medical record documentation.

2022 Updates: Split/Shared Services

Definition of Substantive Portion for E/M Visit Code Families

E/M Visit Code Family	**2022 Definition of Substantive Portion**	**2024 Definition of Substantive Portion**
Other Outpatient*	History, or exam, or MDM, or more than half of total time	More than half of time
Inpatient/Observation/ Hospital/SNF	History, or exam, or MDM, or more than half of total time	More than half of time
Emergency Department	History, or exam, or MDM	More than half of time
Critical Care	**More than half of total time**	More than half of total time

Transmittal R11181, January 2022

Critical Care Shared/Split Billing Scenarios

Physician Billing Scenario	APP Billing Scenario

• Physician documents: 95 minutes of critical care time (99291, 99292 x1)
• APP documents: 60 minutes of critical care time (99291)
• Split/Shared Billing:
  • Physician provided the majority of the time)
  • 155 minutes combined
  • 99291, 99292 x 3
	• Physician documents: 65 minutes of critical care time (99291)
	• APP documents: 78 minutes of critical care time (99291)
	• Split/Shared Billing:
	  • APP provided the majority of the time)
	  • 143 minutes combined
	  • 99291, 99292 x 3

- **I was physically present and directly participated in the patient's care today. I have personally examined the patient and reviewed the chart and medication list, as well as available lab results and imaging studies. I was directly involved in the medical decision-making recorded in _____, MD (Fellow) documentation. I have reviewed and edited the Fellow's note accordingly. My decision-making is summarized below. Time spent caring for this critically ill patient 50 minutes. This time was independent of any time spent teaching or performing any separately billable procedures or services.**
- **"I spent 38 minutes providing critical care services (exclusive of procedures)"**
- **"Care included: History and exam, pressor management, family/patient/medical team discussion regarding treatment decisions. 9:15am-10:00am"**

2023 Medicare Final Rule

- Extend the duration of time that services are temporarily included on the telehealth services list during the PHE for at least a period of 151 days following the end of the PHE, in alignment with the Consolidated Appropriations Act, 2022 (CAA, 2022)
- Allow telehealth services to be furnished in any geographic area and in any originating site setting (including the beneficiary's home)
- Allow certain services to be furnished via audio-only telecommunications systems
- Allowing physical therapists, occupational therapists, speech-language pathologists, and audiologists to furnish telehealth services, will remain in place during the PHE for 151 days after the PHE ends
- Delay the in-person visit requirements for mental health services furnished via telehealth until 152 days after the end of the PHE
- Allow physicians and APPs to continue to bill with the place of service (POS) indicator that would have been reported had the service been furnished in-person
  - These claims will require the modifier "95" to identify them as services furnished as telehealth services
  - Claims can continue to be billed with the place of service code that would be used if the telehealth service had been furnished in-person through the later of the end of CY 2023 or end of the year in which the PHE ends

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The U.S. will extend the COVID-19 public health emergency through at least April 11, 2023, Biden administration officials confirmed to *CNBC* Nov. 11. (Becker's Healthcare)

Behavioral Health Services

- CMS is finalizing the proposal to add an exception to the direct supervision requirement under our "incident to" to allow behavioral health services to be provided under the general supervision of a physician or APP, rather than under direct supervision, when these services or supplies are furnished by auxiliary personnel, such as LPCs and LMFTs
- CMS is also clarifying that any service furnished primarily for the diagnosis and treatment of a mental health or substance use disorder can be furnished by auxiliary personnel under the general supervision of a physician or APP who is authorized to furnish and bill for services provided incident to their own professional services.
- CMS indicated in the final rule that we intend to address payment for new codes that describe caregiver behavioral management training in CY 2024 rulemaking.

OIG Data Brief Key Takeaways

- Findings demonstrate the importance of effective, targeted oversight of telehealth services to ensure that the benefits of telehealth are realized while minimizing risk
- Identified 1,714 providers out of approximately 742,000 whose billing for telehealth services poses a high risk to Medicare
- Each of these providers had concerning billing on at least one of seven measures that may indicate fraud, waste, or abuse
- These providers billed for telehealth services for about half a million beneficiaries
- Many of these providers are a part of the same medical practice as at least one other provider whose billing poses a high risk

CMS Recommendations:

- Strengthen monitoring and targeted oversight of telehealth services
- Provide additional education to providers on appropriate billing for telehealth services
- Improve the transparency of "incident to" services when clinical staff primarily delivered a telehealth service
- Identify telehealth companies that bill Medicare

https://oig.hhs.gov/oei/reports/OEI-02-20-00720.pdf

Telehealth Risk Areas

- Billing an E/M Service for Audio Only Telephone Services
  - Provided by Ancillary Staff
  - 7-day rule not met
  - Medical necessity requirements not met
- Modifier -95 not appended
  - Falsely submitted claim
- Consent not obtained
- Modality not clearly indicated
- Conflicting Medical Record Documentation
- Issues identified and not Self-Reported

Sample Documentation Templates

Patient has verbally consented to this telehealth visit. **If yes, check here: □**	
PATIENT NAME:	DATE:
Session Start Time:	**Names of all persons participating in this service:**
Session End Time:	
Location of Patient:	
Location of Provider:	
Chief Complaint/Reason For Visit:	
IMPRESSION/ASSESSMENT:	
PLAN:	
RECOMMENDATIONS FOR FURTHER TREATMENT:	
"Total clinician time spent on date of this encounter is _____ minutes including preparing to see the patient, obtaining/reviewing and confirming history, virtually examining patient, documenting clinical information in the EHR."	

Patient has verbally consented to this telephonic visit. **If yes, check here: ☐**
Location of Patient:
Location of Provider:
Chief Complaint/Reason for Call:
Medical Discussion:
ASSESSMENT/RECOMMENDATIONS FOR FURTHER TREATMENT:
The total amount of time on the phone in medical discussion and care of this patient: * minutes.**

Chronic Pain Management (CPM) and Treatment Services

- HCPCS codes, **G3002 and G3003**, and valuation for chronic pain management and treatment services (CPM) in 2023
- Finalized the CPM codes to include the following elements in the code descriptor:
  - diagnosis
  - assessment and monitoring
  - administration of a validated pain rating scale or tool
  - the development, implementation, revision, and/or maintenance of a person-centered care plan that includes strengths, goals, clinical needs and desired outcomes
  - overall treatment management
  - facilitation and coordination of any necessary behavioral health treatment
  - medication management
  - pain and health literacy counseling
  - any necessary chronic pain related crisis care
  - ongoing communication and coordination between relevant practitioners furnishing care, such as physical and occupational therapy, complementary and integrative care approaches, and community-based care, as appropriate

G3002: Chronic pain management and treatment, monthly bundle including, diagnosis; assessment and monitoring; administration of a validated pain rating scale or tool; the development, implementation, revision, and/or maintenance of a person-centered care plan that includes strengths, goals, clinical needs, and desired outcomes; overall treatment management; facilitation and coordination of any necessary behavioral health treatment; medication management; pain and health literacy counseling; any necessary chronic pain related crisis care; and ongoing communication and care coordination between relevant practitioners furnishing care, e.g. physical therapy and occupational therapy, complementary and integrative approaches, and community-based care, as appropriate. required initial face-to-face visit at least 30 minutes provided by a physician or other qualified health professional; first 30 minutes personally provided by physician or other qualified health care professional, per calendar month. (when using g3002, 30 minutes must be met or exceeded.)

G3003: Each additional 15 minutes of chronic pain management and treatment by a physician or other qualified health care professional, per calendar month. (list separately in addition to code for g3002. when using g3003, 15 minutes must be met or exceeded.)

Audiology Services

- CMS finalized a policy allowing beneficiaries direct access to an audiologist without an order from a physician or APP for non-acute hearing conditions (e.g., hearing aids, or examinations for the purpose of prescribing, fitting, or changing hearing aids)
- Use of a new modifier "AB"
- Services can be billed using the codes audiologists already use with the new modifier and include only those personally furnished by the audiologist
- Audiologists may use modifier "AB" along with the finalized list of 36 CPT codes, for dates of service on and after January 1, 2023
- Permit audiologists to bill for this direct access (without a physician or practitioner order) once every 12 months per beneficiary
- Medically reasonable and necessary tests ordered by a physician or other practitioner and personally provided by audiologists will not be affected by the direct access policy, including the modifier and frequency limitation

2023 Compliance Strategies

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Proposed Regulations – Risk Areas for Providers

- Compliance program must apply to:
  - billings;
  - payments;
  - ordered services;
  - medical necessity;
  - quality of care;
  - governance;
  - mandatory reporting;
  - credentialing;
  - contractor, subcontractor, agent, or independent contract oversight; and
  - other risk areas that are or should reasonably be identified by the provider through "organizational experience"
- Written Policies of Compliance Program
- Compliance Officer and Compliance Committee
- Compliance Training and Education
  - risk areas and organizational experience of the Required Provider
  - written policies, procedures, and standards of conduct related to compliance
  - corrective action plans and response to compliance issues;
  - coding and billing requirements and best practices

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Strategies for Provider Engagement and Education

- **Physician/APP Champions.** Identify physician/APP champions to work with compliance. The clinical champions should also be EMR superusers
- **Create partnerships.** Engage and partner with Physician/APP champions to develop solutions for improved efficiency and quality of care
- **Set compliance expectations.** Determine your organization's compliance thresholds
- **Communication.** Keep the lines of communication open between providers and compliance. Providers appreciate feedback and guidance

Documentation Improvement Tips

- **Standardize practices.** Use benchmarks and industry standards to create guidelines and map out processes for your organization
- **Documentation Templates.** Work with Providers and IT to develop comprehensive and compliant templates
- **Auditing and Monitoring.** Annual provider audits and focused monitoring audits (e.g., Modifier -25, Telehealth services, Shared/Split services, Incident-to, etc)
- **Education. Education. Education.** Be creative. Customize trainings to provider needs and areas of risk

QUESTIONS

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VMG HEALTH

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