Medicare to Providers “Tell Us More”

Medicare recently started denying an increased number of claims because documentation submitted for diagnostic tests does not include signed test orders or evidence of intent (MD progress notes listing tests needed) and evidence of medical necessity (description of clinical conditions and treatment showing the need for the testing.)

Most of us who have gone through the implementation of a EMR realize that electronic medical records (EMRs) do not always “tell the story” of a visit in the way that paper records used to. Encounters are documented without the glue that allows an auditor to understand what went on during the visit. Here are three ways to make sure that your documentation meets requirement for Medicare and other payers.

Establish Medical Necessity: Make sure the test is attached to the right diagnosis

Some providers attach all diagnoses assigned to a visit to any/every test ordered and

performed. This is incorrect. All diagnoses can be attached to the Evaluation & Management (E/M) code, since all were addressed during the visit. Don't list any diagnoses from previous visits that were not addressed at the current visit unless you note their impact on your decisions for care at the current visit.

Remember that screening tests and diagnostic tests are two different things. **A screening test** is ordered when you are looking for something with no provocation. **Wikipedia** states that a screening test "may be performed to monitor disease prevalence, manage epidemiology, aid in prevention, or strictly for statistical purposes."

A diagnostic test is ordered when there is a sign or symptom that prompts the provider to look for the cause. **Wikipedia** defines a diagnostic test as "a procedure performed to confirm, or determine the presence of disease in an individual suspected of having the disease, usually following the report of symptoms, or based on the results of other medical tests."

According to **Medscape**, the 5 main reasons for any test are as follows:

- **Screening:** Screen for disease in asymptomatic patients. For example, a prostate-specific antigen (PSA) test in men older than 50 years.
- **Screening:** A test may be performed to confirm that a person is free from a disease or condition. For example, a pregnancy test to exclude the diagnosis of ectopic pregnancy.
- **Diagnostic:** Establish a diagnosis in symptomatic patients. For example, an ECG to diagnose ST-elevation myocardial infarction (STEMI) in patients with chest pain.
- **Diagnostic:** Provide prognostic information in patients with established disease. For example, a CD4 count in patients with HIV.

- **Diagnostic:** Monitor therapy by either benefits or side effects. For example, measuring the international normalized ratio (INR) in patients taking warfarin.

Reveal your decision making in the record

- *Need add'l tests to est. xxxxxx. Plan to…*
- *Return in 3 wks and repeat test to establish…*
- *DM worsening – will….*
- *Consider d/c xxxxxx medication if fatigue persists.*
- *Hypothyroidism vs. anemia?*
- *Fatigue most likely sec. to HTN meds – r/o electrolyte abn.*
- *DM stable, continue current regimen, recheck in 3 months.*

Don't forget the signatures!

A signature log can be as simple as entries on a document such as:

Provider Name (printed): _____

Full signature (written by provider): _____

Initials (written by provider): _____

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