

HCCA'S 12TH ANNUAL COMPLIANCE INSTITUTE

APRIL 13-16, 2008 | NEW ORLEANS, LA | HILTON RIVERSIDE NEW ORLEANS

**Developing Custom
Evaluation and Management
Documentation Forms**

It's Easier Than You Think!

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April 2008



QUIET, PLEASE!

**Please turn your
cell phones and
pagers to silent
operation.**

**Thank you
very much!**



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Disclaimer

- **This presentation is for informational purposes only. It is not and should not be taken as legal advice. If you need legal advice, please contact an attorney.**
- **This information is not representative of the policies or procedures of any specific health care company, facility or organization.**



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Objectives

At the end of this session, you will be able to perform the following:

- **Explain the advantages of developing custom Evaluation and Management (E/M) documentation forms**
- **List criteria for forms design**
- **Know the appropriate program to use to easily create custom forms**
- **Select information to include on forms**



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Why Create Custom Forms Now in an Electronic Age?

- Forms companies cannot respond to the documentation needs of all individual practices and specialties
- Custom forms will prompt physicians and non-physician practitioners (NPPs) to follow Medicare Documentation Guidelines
- Custom forms will better prepare physicians to adapt to electronic medical record systems
 - There has been at least one hospital system that had to abandon its electronic medical record and go back to a paper system



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Getting Started/Getting Support

- Before undertaking changing forms, start by recruiting champions to buy-in and support the project
 - Physicians
 - Non-physician practitioners
 - Medical Records
 - Compliance
 - Coding
 - Billing



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Getting Started Forms Design

- A good form must have a good design
- Institutions and large practices may have a Forms Committee—get forms criteria from committee and follow criteria *carefully*
- If no criteria, or if working in a small practice, work with your physicians and/or NPPs to create forms criteria



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Forms Criteria

- Paper Size
 - Perforations
 - Borders
- Paper Weight
- Paper Color/Ink Color
- Margins
- Placement of Patient Identification
 - Computer Generated
 - Farrington Plate
 - Labels



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Forms Criteria, continued

- **Form Title**
- **Page Numbering**
- **Forms Numbering**
 - **Original Version**
 - **Revisions**
- **Logos**
- **Barcodes**
- **Fonts**
 - **Type**
 - **Minimum and Maximum Sizes**
- **Shading**



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Forms Criteria, continued

- **Multi-part forms**
- **Abbreviations**
- **Reproduction of forms**
 - **Printing**
 - **Photocopying**
- **Documentation on forms**



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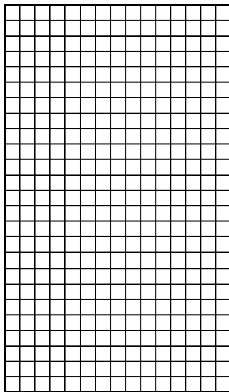
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The Form Template

NEW PATIENT or CONSULTATION FORM Name of Department _____ Page 1 of 2		NEW PATIENT or CONSULTATION FORM Name of Department _____ Page 2 of 2	
Date of Service: ____/____/____ Time of Service: ____ AM ____ PM		Date of Service: ____/____/____ EXAM	
Is this a consultation? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name and address of requesting physician: _____ (Nonteaching physicians' consultations should be written reply to the requesting physician.)		When this box is checked, more than fifty percent (50%) of this service was time spent counseling the patient and/or coordinating patient care. Total Time of Visit: _____ Time Spent in Counseling: _____ Details of counseling and/or coordination of care MUST be documented below!	
CHIEF COMPLAINT (IC)-Reason for patient's visit today: _____ _____ _____			
HISTORY AS REPORTED BY PROVIDER: History of Present Illness (Location, Quality, Severity, Duration, Timing, Context, Modifying Factors, Associated signs/symptoms) _____ Past Status of Chronic or Inactive Conditions (3 or more - extended w/o HP) _____ (1, 2 brief, 4+ extended)			
REVIEW OF SYSTEMS (GROUPS) (GENERAL, FAMILY, AND SOCIAL HISTORY) (P/F): Use Patient Health Questionnaire dated (mm/dd/yyyy) Provider Comments - Review of Systems for additional ROS and P/FHS: _____ _____		PHYSICIAN: _____ PC/M: _____	
Has patient having any current problems, signs, or symptoms in any of the following areas? (Provide IC/CC comment on all "Yes" responses.)		RESIDENT/FELLOW'S SIGNATURE: _____ DATE: ____/____/____ TIME: ____ AM ____ PM (Include credentials, i.e., M.D., D.O., and PGY status)	
YES NO YES NO <input type="checkbox"/> Constitutional <input type="checkbox"/> Integumentary (Skin and Head) <input type="checkbox"/> Hematology <input type="checkbox"/> Eye <input type="checkbox"/> Neurological <input type="checkbox"/> Psychiatric <input type="checkbox"/> Endocrine <input type="checkbox"/> Ear, Nose, Throat <input type="checkbox"/> Cardiovascular <input type="checkbox"/> Hematology/Lymphatic <input type="checkbox"/> Allergy/Immunology <input type="checkbox"/> Respiratory <input type="checkbox"/> Gastrointestinal <input type="checkbox"/> Other _____ <input type="checkbox"/> Musculoskeletal <input type="checkbox"/> Other _____		TEACHING PHYSICIAN DOCUMENTATION: Additional documentation of teaching physician: _____ _____ _____	
Medications (prescription, OTC, vitamins, herbs)-include oral, eye drops, ear drops, nose drops, suppositories, skin lotions and creams used on a <u>regular</u> basis: <input type="checkbox"/> All other systems <u>assessed</u> and negative (mm/dd/yyyy) Review of Systems: <u>assessed</u> <input type="checkbox"/> extended <input type="checkbox"/> complete		PATHY (TEACHING HOSPITALS) (STATE) (CITY) (ZIP) (PHONE) (FAX) (E-MAIL) _____ <input type="checkbox"/> I was present with Dr. _____ (Name of Resident/Fellow) during the history and exam. I discussed the case with the resident/fellow and agree with the findings and plan as documented in the resident's note except as noted. <input type="checkbox"/> I saw and evaluated the patient. I discussed the case with Dr. _____ (Name of Resident/Fellow) and agree with the resident's/fellow's findings and plan as documented in the resident's/fellow's note except as noted.	
Previous Surgeries/Dates: _____ _____		PROVIDER'S SIGNATURE-LATE ENTRY (if applicable) _____ DATE: ____/____/____ TIME: ____ AM ____ PM (Include credentials, i.e., M.D., D.O.)	
What is patient's Social History? Marital Status (circle one): _____ Domestic Partnered Married Single Widowed Current Employer: _____ Patient's Occupation: _____ Does patient smoke? Cigarettes _____ (if of pack/day) Pipes _____ (if of bowl/day) For how many years? _____ Does patient drink alcohol? How many drinks? _____ per day _____ per week _____ per month Does patient use illicit drugs? If yes, what kind? _____ How often? _____ Is patient sexually active? Yes <input type="checkbox"/> No <input type="checkbox"/> Does patient use condoms? (circle one) Always Sometimes Never Does patient use bath/shower? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, describe: _____		PROVIDER'S SIGNATURE-LATE ENTRY (if applicable) _____ DATE: ____/____/____ TIME: ____ AM ____ PM (Include credentials, i.e., M.D., D.O.)	
What is the Health Status of the Patient's Family? Mother: _____ Father: _____ Grandparents: _____ In-laws/Sister: _____		NEW PATIENT or CONSULTATION FORM Street Address, Suite Number Name of Department City, State, Zip+4 City, State, Zip+4 Form ##### Original Form mmm/yyyy	
Family Illnesses: History of Heart Disease (heart attack, heart failure) <input type="checkbox"/> yes <input type="checkbox"/> no History of diabetes? <input type="checkbox"/> yes <input type="checkbox"/> no History of stroke(s) <input type="checkbox"/> yes <input type="checkbox"/> no History of high blood pressure? <input type="checkbox"/> yes <input type="checkbox"/> no		HCCA HEALTH CARE COMPLIANCE ASSOCIATION www.hcca-info.org 888-580-8373	

It all starts with Microsoft® Excel

- ✓ The grid measurements are as follows: Rows=11, Column=1
 - The grids are not visible
 - Adjust grids as necessary
- ✓ There is a border around the document
 - Helps keep documentation neater



Add the Form Title

NEW PATIENT *or* CONSULTATION FORM

Name of Department

Page 1 of 2

- **Combine forms with similar uses whenever possible to save paper and printing costs**
- **Print form name at the top and the bottom of the form on the front and back of each form so that form can be easily retrieved from either direction**

NEW PATIENT *or* CONSULTATION FORM
Name of Department
Page 1 of 2 Form # Original Form mm/yyyy



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Date of Service/Time of Service

|Date of Service / / |Time of Service : ☰ AM ☰ PM|

- **Inpatient and outpatient hospital records MUST document the date and the time of service**
- **Office records MUST document the date of service, and as a best practice, should also document the time of service. Time-based services provided in the office setting MUST document time!**



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Date of Service/Time of Service, continued

|Date of Service / / |Time of Service : ☰ AM ☰ PM|

- The Date of Service **MUST** be documented for **every service** provided in the medical record. If a service continues onto more than one page, the Date of Service **MUST** be documented on each page, front and back!



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Consultation or New Patient Visit?

Is this a consultation? ☑Yes ☑No If yes, name and address of requesting physician

IMPORTANT REMINDER: Consultations include a written reply to the requesting physician!

- Prompts physicians to ask the pertinent questions and obtain information necessary to document an office or outpatient consultation
- Reminds physicians of the required written reply to the requesting physician for consultations



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Chief Complaint

CHIEF COMPLAINT (CC)—Reason for patient's visit today

- Prompts providers to separately document the Chief Complaint
- Some providers are more familiar/comfortable with the term "Reason for the patient's visit"—include information that will help get the appropriate documentation



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History of Present Illness (HPI)

HISTORY - COMPLETED BY PROVIDER

History of Present Illness (*Location, Quality, Severity, Duration, Timing, Context, Modifying Factors, Associated signs/symptoms*)

OR Status of Chronic or Inactive Conditions (3 or more = extended w/o HPI)

(1-3 brief, 4+ extended)

- Prompts providers to list all eight elements of the HPI
- Informs providers of the number of elements necessary to achieve various levels of HPI
- **DOES NOT** steer providers to specific codes—steering is inappropriate



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The Patient Health Questionnaire

☐ See Patient Health Questionnaire dated _____ (mm/dd/yyyy) for additional ROS and PFSH.

- **Anyone can fill out the Patient Health Questionnaire**
 - Patient
 - Power of Attorney for Health Care
 - Nurse
 - Resident/Fellow
- **Physician must comment on positive findings, sign and date the questionnaire**



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The Patient Health Questionnaire, continued

☐ See Patient Health Questionnaire dated _____ (mm/dd/yyyy) for additional ROS and PFSH.

- **Gives patients something to do while they are waiting to see their physician**
- **Saves provider documentation time**
- **Providers can refer to the Patient Health Questionnaire when documenting Review of Systems (ROS) and Past, Family and Social History (PFSH) for follow-up visits**
(NOTE: Any reference to other documentation in the chart MUST include the date of the documentation!)

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Previous Surgeries

- Prompts providers to document patients' surgeries and the dates of those surgeries

Previous Surgeries/Dates: _____



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Allergies

- Prompts providers to document patients' allergies
- Could also be more detailed if room permits
 - Animal dander allergies
 - Drug allergies
 - Food allergies/Plant allergies

Allergies _____

Social History

- Prompts provider to document
 - Marital Status
 - Living Arrangements
 - Current Employment/Occupation
 - Smoking
 - Alcohol Consumption
 - Illicit Drug Use
 - Sexual Activity
 - Other High Risk Behavior

What is patient's Social History? Marital Status (circle one): Divorced Domestic Partnered Married Single Widowed
 Who lives with the patient? _____ Current Employer _____ Patient's Occupation _____
 Does patient smoke? Cigarettes _____ (# of packs/day) Cigars _____ (# of cigars/day) Pipe _____ (# of bowls/day) For how many years? _____
 Does patient drink alcohol? _____ How many drinks? _____ per day _____ per week _____ per month
 Does patient use illicit drugs? _____ If yes, what kind? _____ How often? _____
 Is patient sexually active? Yes No Does patient use condoms? (circle one) Always Sometimes Never
 Other contraceptive use? Yes No If yes, what kind? _____
 Other high risk behavior? Yes No If yes, describe _____

Family History

- Prompts providers to document health status of patients'—
 - Parents
 - Grandparents
 - Siblings
- Prompts providers to document family history of—
 - Heart disease
 - Strokes
 - High Blood Pressure
 - Diabetes

What is the Health Status of the Patient's Family?
 Mother: _____ Father: _____
 Grandparents: _____ Brothers/Sisters: _____
 Family Illnesses:
 History of Heart Disease (heart attack, heart failure) yes no
 History of strokes? yes no History of high blood pressure? yes no History of diabetes? yes no

Patient Identification

- Prompts provider or staff to document necessary information to meet JCAHO and Medicare requirements
- Provider (or staff) ***MUST*** document patient's name and second identifier on each page (front and back) that has documentation on it.
 - Second identifier can be Date of Birth or Medical Record Number



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Practice Identification Logo Placement

- Be sure that the custom form identifies the practice name and location
- If the practice has a logo, place the logo on the form



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"Tumbleweed" vs. "Head to Head"

- **If form is hole punched at the top, have form printed "tumbleweed" style (second page is upside down from first page, and will appear upright when front of the page is turned to the back of the same page)**
- **If form is hole punched on the left side, have form printed "head to head" style (second page is the same direction as the first page, and will appear upright when front of the page is turned to the back of the same page)**



Exam


- **Reminds providers of the option of documenting time spent counseling the patient and/or coordinating patient care**
- **Exam section is blank, so specialists can either create template information for the exam section or document the exam section as free text**
- **Section can be lined or unlined to suit providers**



Resident's/Fellow's Signatures

- Residents/Fellows must sign to document when they have participated in services
- Signatures must include professional credentials (i.e., M.D., D.O.) and the Post-Graduate Year (PGY) status
- Date and time of signatures must be documented

RESIDENT'S/FELLOW'S SIGNATURE (include credentials, i.e., M.D., D.O., and PGY status)			DATE	TIME
				<input type="checkbox"/> AM <input type="checkbox"/> PM


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Physicians at Teaching Hospitals (PATH)

- For teaching facilities, prompts teaching physicians to document the correct PATH statements and additional documentation when they disagree with residents/fellows

TEACHING PHYSICIAN DOCUMENTATION	Additional documentation of teaching physician:

PATH (PHYSICIANS AT TEACHING HOSPITALS) STATEMENTS--Check *ONLY* those boxes that are applicable!

When this box is checked, the provider signing below makes the following attestation:

I was present with Dr. _____ (Name of Resident/Fellow) during the history and exam. I discussed the case with the resident/fellow and agree with the findings and plan as documented in the resident's/fellow's note except as noted.

I saw and evaluated the patient. I discussed the case with Dr. _____ (Name of Resident/Fellow) and agree with the resident's/fellow's findings and plan as documented in the resident's/fellow's note except as noted.


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Providers' Signatures

- Providers must sign to document their participation in services
- Signatures must include professional credentials (i.e., M.D., D.O.)
- Date and time of signatures must be documented
- Late entry signatures must use the "LATE ENTRY" signature blocks

PROVIDER'S SIGNATURE (include credentials: i.e., M.D., D.O.)	↓ DATE ↓	↓ TIME ↓
		ⓐ AM ⓑ PM
PROVIDER'S SIGNATURE--LATE ENTRY (if applicable) (include credentials: i.e., M.D., D.O.)	↓ DATE ↓	↓ TIME ↓
		ⓐ AM ⓑ PM



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Prototype is done Next Steps...

1. Meet with champions to get feedback.
Revise prototype as necessary.
2. Meet with physicians and non-physician practitioners to get specialty-specific information. Be flexible where possible.
Get feedback on specialty-specific forms design.



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Prototype is done Next Steps...

- 3. Implement custom forms for each specialty.**
- 4. Keep a copy of each completed form on file. As requests for changes are suggested, file the recommendations with the form. When the form is ready for reprinting, pull the form and the suggestions and evaluate the suggestions with the appropriate representatives of the department before revising the form.**
- 5. Revise the form as necessary and reprint.**



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Any questions?



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