Documentation and Coding in Hospital Medicine

SCP HEALTH

Documentation Assurance Team

Our Purpose:

✓Collaborate with providers to assist in understanding the coding methodology in relation to clinical documentation.

✓Monthly, you will receive documentation feedback as well as helpful tips pertaining to documentation if applicable

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Presentation Outline/Agenda

1. Hospital Medicine Documentation Guidelines for 2023
2. Telemedicine
3. Initial/Subsequent Hospital Care
4. Discharge Day Management
5. Critical Care
6. Additional Patient Care Services
7. NP/PA Documentation
8. Teaching Physician Services
9. Recap, Reminders and Provider Feedback Process
10. Provider Portal and mySCP Care

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Hospital Medicine Documentation Guidelines

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Documentation Tips for HM

CMS 2023 Documentation Changes Overview

Why:

- Streamlining processes and addressing administrative burden
- Reducing documentation requirements of history and physical exam
- Emphasizing medical decision making (MDM) documentation

What:

- Elements of history and physical exam (H&P) are no longer a factor for coding and billing
- A medically appropriate and descriptive H&P still needs to be documented
- Billing will be solely based on MDM or time
  - Time is not a factor for the Emergency Department
  - Revision to the rules for using time to assign an E&M code (Hospital medicine, Urgent Care)
  - Modifications to the criteria for determining the level of medical decision making
- Observation code sets eliminated moved to combine with inpatient code sets
  - Time needs to be documented on all inpatient/observation discharge summaries

Documentation Tips for HM

E&M Documentation Requirements

Evaluation and Management (E&M) Documentation Requires the following:

- **Chief Complaint** – is required and can be inferred
- **History**
  - No specifics required
  - Clinician to document what was medically appropriate
- **Exam**
  - No specifics required
  - Clinician to document what was medically appropriate
- **MDM or Time**
  - No time for Emergency Department
  - MDM – three tables – requires 2 of the 3 tables
  - More stringent MDM requirements

Documentation Tips for HM

History and Physical Exam

- Your History and Physical exam must be medically appropriate to support the Medical Necessity and E&M Level assignment for each date of service (DOS)
- History and Physical exam are still used to evaluate and plan the patient's immediate treatment and monitor the overall healthcare of that patient
- A descriptive History and Physical exam will ensure that any internal or external reviewers will understand the complexity of problems addressed to accurately determine the medical decision making
- If elements of the History are unobtainable due to patient's condition, document a History Caveat
  - i.e., "History unobtainable due to …" (must state reason – dementia, respiratory status, unconscious, etc.)

Documentation Tips for HM

History

- **Chief Complaint** is required and can be inferred
- **History of Present Illness (HPI)**
  - Describes the chief complaint in greater detail and paints the clinical pictures of the patient's story.
  - There are eight (8) areas that may be addressed (Location, Duration, Severity, Timing, Context, Modifying factors, Associated signs and symptoms, and Quality)
- **Review of Systems (ROS)**
  - An inventory of body systems obtained through a series of questions seeking to identify signs or symptoms which the patient may be experiencing or has experienced.
  - Constitutional, Eyes, ENT, CVS, Resp, GI, GU, Musculoskeletal, Integumentary, Neuro, Psych, Endocrine, Hematologic/Lymphatic, Allergic/Immunologic
- **Past Family Social History (PFSH)**
  - Past history – patient's past experiences with illnesses, operations, injuries, and treatments
  - Family history – a review of medical events in the patient's family, including diseases which maybe hereditary or place the patient at risk
  - Social history – an age-appropriate review of past and current activities of the patient in regard to smoking, alcohol, drugs, job duties, stressors, etc.

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Exam

- **Exam**
  - Examination of organ systems pertinent to the patient's presenting problems
  - There are twelve (12) organ systems that may be addressed
    - Constitutional
    - Eyes
    - Ear, nose, mouth, and throat
    - Cardiovascular
    - Respiratory
    - Gastrointestinal
    - Genitourinary
    - Musculoskeletal
    - Skin
    - Neurological
    - Psychiatric
    - Hematologic/Lymphatic/Immunologic

Documentation Tips for HM

Medical Decision Making (MDM)

➢Medical Decision Making (MDM) determines the E&M level assignment and without detailed accurate documentation a chart maybe coded to a lower E&M level

➢MDM - Complexity of evaluating the patient's presentation, establishing a diagnosis, and selecting management/treatment options

➢Three areas for medical decision making

- Number and complexity of **problems** addressed during the encounter
- Amount and/or complexity of **data** to be reviewed and analyzed
- **Risk** of complications and/or morbidity or mortality of **patient management**

Documentation Tips for HM

Medical Decision Making (MDM) – Problems Addressed

- **Number and complexity of problems addressed during the encounter (COPA) for each DOS**
  - Patient currently has or that the clinician is considering and evaluating:
    - Diagnosis, signs and symptoms, co-morbidities (evaluated/treated), and differential diagnoses
  - Document all problems addressed for each date of service

- **Problem addressed:**
  - A disease, condition, illness, injury, symptom, sign, finding, complaint, or other item is addressed at the encounter with or without a diagnosis being established at the time of the encounter
  - Is addressed or managed when it is evaluated or treated at the encounter by the clinician reporting the service
  - Includes consideration of further testing or treatment that may not be elected due to risks or benefit analysis
  - Does not include referral without evaluation and a problem that is being managed by another clinician that does not get evaluated
    - i.e., oncologist handling a bladder cancer that is not evaluated at the time of visit for chest pain

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Medical Decision Making (MDM) – Data Reviewed and Analyzed

- **Amount and/or complexity of data to be reviewed and analyzed**
  - Ordered/Reviewed/Considered but not selected after shared decision making:
    - Ancillary tests
    - Radiology (X-rays, CTs, Ultrasounds, MRIs, etc.)
    - EKGs
  - Documentation of any of the following:
    - Independent historian (Parent, Guardian, Surrogate, Spouse, Witness, Children of elderly pts)
    - Independent visualization and interpretation of radiology (X-rays, CTs, US) or EKG
    - Discussions with external clinicians or other qualified health care professionals
    - Review/summarization of prior external notes or results (i.e., ED visit, SNF or NF, Consults, PMD)

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Medical Decision Making (MDM) – Data cont.

- **Tests Ordered/Reviewed/Considered**
  - Documentation should include each unique test ordered/reviewed or considered but not selected after shared decision making
  - Documentation should include these considerations and discussions
    - i.e., Patient requesting diagnostic imaging that is not necessary for their condition and discussion of lack of benefit may be required
    - i.e., A test may normally be performed but due to the risk for a specific patient it is not ordered
  - Shared decision making involves patient and family preferences, education, and explaining risk and benefits of management options

- **Independent historian**
  - Provides a history in addition to a history provided by the patient who is unable to provide a complete and reliable history
    - i.e., due to developmental stage, dementia, or psychosis
  - Should provide additional information and not merely restate information that may have been provided by the patient
  - Does not need to be obtained in person but does need to be obtained directly from the historian
  - Documentation should reflect who the historian is and what part of the history they provided
  - Does not include translation services

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Medical Decision Making (MDM) – Data cont.

- **Independent visualization and interpretation** does not include radiology studies interpreted by a radiologist that were not also visualized/interpreted by you
- **Discussions**
  - Requires direct interactive exchange – does not include sending chart notes or written exchanges
  - Includes conversations with other clinicians who have performed an interpretation
    - i.e., cardiologist for a review of a cardiac cath; radiologist regarding head CT with evidence of subdural bleed
  - Includes conversations with professionals that may be involved in the management of the patient
    - i.e., PCP, referral physician, another specialist, lawyer, parole officer, case manager, teacher
  - Does not need to be in person
  - Does not include discussion with family or caregivers
  - Documentation should include who was called and what was discussed
- **External Notes Reviewed and Summarization**
  - External records, communications, and/or test results from an external physician, other qualified healthcare professional, facility, or healthcare organization
  - External physician or other qualified healthcare professional is a distinct group or different specialty or sub-specialty
    - i.e., HM clinician reviewing ED visit, SNF or NF, Consults, PMD records

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Medical Decision Making (MDM) - Risk

- **Risk of complications and/or morbidity or mortality of patient management**
  - Ordered/Considered but not selected after shared decision making:
    - Medications (RX or OTC)
    - Parenteral controlled substances
    - Drug therapy requiring intensive monitoring for toxicity
    - Decision regarding hospitalization, or escalation of hospital level care
    - Decision not to resuscitate or de-escalate care due to poor prognosis
    - Diagnosis or treatment significantly limited by Social Determinants of Health (SDOH)
    - Decision regarding elective or emergency major/minor surgery

Documentation Tips for HM

Medical Decision Making (MDM) – Risk cont.

- **Risk of patient management**
  - Level of risk is based on the consequences of the problems addressed at the encounter when appropriately treated
  - Includes:
    - Management options selected/considered but not selected after shared decision making with patient and/or family
      - i.e., decision not to escalate a patient to higher level of care that would generally warrant ICU care, but goal is palliative treatment
      - Shared decision making involves patient and family preferences, education, and explaining risk and benefits of management options
    - The need to undergo further testing, treatments, or hospitalization
- **Prescription (RX) Drug Management**
  - RX includes a review of the patient's current medications, those ordered, and those prescribed at discharge
    - Note: simply listing current medications without documenting that you reviewed is not considered prescription drug management

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Medical Decision Making (MDM) – Risk cont.

- **Social Determinants of Health (SDOH)**
  - Economic and social conditions that influence the health of patients and communities
  - Patient's who are mentally challenged, psychiatrically, or chemically impaired
  - Documentation should indicate the SDOH and how it impacted the medical decision making process
  - Common examples include:
    - Financial resource strain / unemployment
    - Food insecurity
    - Transportation needs
    - Physical activity
    - Stress
    - Social connections
    - Housing stability/homeless
    - Early childhood development
    - Addiction, i.e., alcohol, drugs, etc.
    - Education/literacy
    - Access to medical care
    - Intimate partner violence

Documentation Tips for HM

2023 MDM Table

2023 E&M Documentation Guidelines

Medical Decision Making (MDM) – Overall

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MDM	Table A. Number and Complexity of Problems Addressed	Table B. Amount and/or complexity of Data to be Reviewed and Analyzed	Table C. Risk of Complication and/or Morbidity or Mortality of Pt Mgmt.
Straightforward	Minimal - 1 self-limited or minor problem	Minimal or none	Minimal risk of morbidity from add 'l diagnostic testing or tx

Low	Low
	• 2 or more self-limited or minor problems
	• 1 stable chronic illness
	• 1 acute, uncomplicated illness or injury
	• 1 stable acute illness
	• 1 acute uncomplicated illness or injury requiring hospital inpatient or observation level of care
		Limited (must meet 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
		Category 2: Assessment requiring an independent historian(s)
			Low risk of morbidity from add 'l diagnostic testing or tx

Moderate	Moderate
	• 1 or more chronic illness with exacerbation, progression, or side effects of treatment
	• 2 or more stable chronic illnesses
	• 1 undiagnosed new problem with uncertain prognosis
	• 1 acute illness with systemic symptoms
	• 1 acute complicated injury
		Moderate (must meet at least 1 of the 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)
		Category 2: Independent interpretation of tests
		• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported)
		Category 3: Discussion of management or test interpretation
		• Discussion of management or test interpretation with external physician/other qualified healthcare professional\appropriate source (not separately reported)
			Moderate risk of morbidity from additional diagnostic testing or treatment
			Ex.
			• 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
	• 1 acute or chronic illness or injury that poses a threat to life or bodily function
		Extensive (must meet at least 2 of the 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)
		Category 2: Independent interpretation of tests
		• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported)
		Category 3: Discussion of management or test interpretation
		• Discussion of management or test interpretation with external physician/other qualified healthcare professional\appropriate source (not separately reported)
			High risk of morbidity from additional diagnostic testing or treatment
			Ex.
			• 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 to de-escalate care because of poor prognosis
			• Parenteral controlled substances

*Overall MDM - 2 of the 3 tables must be met or exceeded

Documentation Tips for HM

Time

➢ **Time spent with patient**

- Time is defined as total time spent by the clinician both face to face and non-face to face activities related to the patient's visit performed on the DOS.
- Includes:
  - Preparing to see the patient (reviewing test results)
  - Obtaining or reviewing histories
  - Performing a medically appropriate examination and/or evaluation
  - Counseling and educating the patient, family, or caregiver
  - Ordering medications, tests, or procedures
  - Discussion with other health care professionals
  - Documenting in the record
  - Interpreting and communicating test results (not separately billable)
  - Care coordination (not separately reported)
  - Procedures performed when not separately billable services
- Do not count time spent on the following:
  - Procedures and other services reported separately
  - Teaching that is general and not part of patient management
  - Travel

Prolonged care can be applied if time spent exceeds the maximum time for the level of care applied.

- **Must be 15 minutes additional** to apply the prolonged care code
- Inpatient/Observation initial visit: minimum of **90 minutes** for prolonged care
- Inpatient/Observation subsequent visit: minimum of **65 minutes** for prolonged care

✓**Always document your time on an inpatient/observation discharge visits**

Documentation Tips for HM

E&M Documentation Requirements Summary

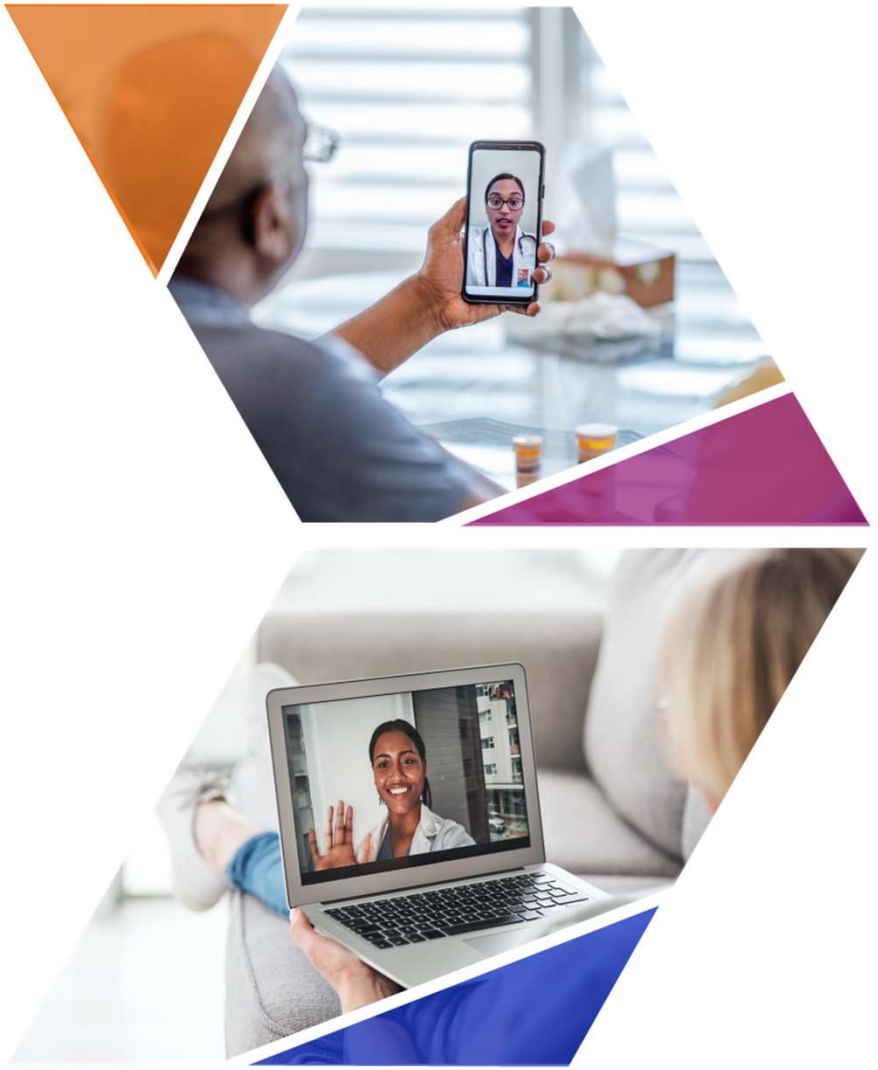
- A medically appropriate and descriptive H&P needs to be documented for each DOS
- Billing will be based on MDM or Time
- Documentation should include as applicable:
  - If history is obtained from an independent historian along with what information the historian provided
    - i.e., Parent, Guardian, Surrogate, Spouse, Witness, Children of elderly pts, etc.
  - Problems addressed that the Patient currently has or that the clinician is considering and evaluating:
    - Diagnosis, signs and symptoms, co-morbidities (evaluated/treated), and differential diagnoses
  - Document chronic illnesses impacting care
    - Diabetes, hypertension, hyperglycemia, chemotherapy
  - Diagnostic tests ordered, reviewed or appropriately considered even though not ultimately performed
    - Ancillary studies, Xray, CTs, MRIs, etc.
  - Independent visualization and interpretation of X-Rays, EKGs, CT scans, and Ultrasounds

Documentation Tips for HM

E&M Documentation Requirements Summary – cont.

- Discussions with external clinicians or other qualified health care professionals - Emergency Department, consultant (GI, Neuro, Social Work), PMD, Cardiology/Radiology (test interps)
  - i.e., patient management or test interpretations
- Review/summarization of prior external notes or results
  - i.e., ED visit, SNF or NF, Consult, PMD
- Prescription medications reviewed, ordered, RX on discharge, or considered even if not given
  - antibiotics, antivirals, pain medication
- If care is affected by social determinants of health
  - Homeless, literacy, access to medical care, food insecurity, financial resource strain, transportation needs, and intimate partner violence, etc.
- Admission from Observation to inpatient, transfer, or escalation of hospital level care
- Document your time if it exceeds 75 minutes on an inpatient/observation initial visit
- Document your time if it exceeds 50 minutes on an inpatient/observation subsequent visit
- Always document your time on an inpatient/observation discharge visit

Telemedicine



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Documentation Tips for HM

Telemedicine Encounters

➢**What are they?**

- Clinician and Patient are in **different** physical locations (ex: the patient is in the hospital, but the clinician is at home).

➢**How should I document this type of encounter?**

- A statement that the service was provided using telemedicine
- Type of Software used(Audio/Visual)
- The location of the patient
- The location of the provider
- The names of all persons participating in the telemedicine service and their role in the encounter

➢**Please Note**: These patient encounters should be documented the same as a routine, in-house encounters

Sample statement to use-
This patient visit was performed using telemedicine using the secure Vidyo software platform with 2 way audio/video. The clinician was located off-site and the patient is located in the hospital. The aforementioned video software was utilized to document the relevant history and physical exam.

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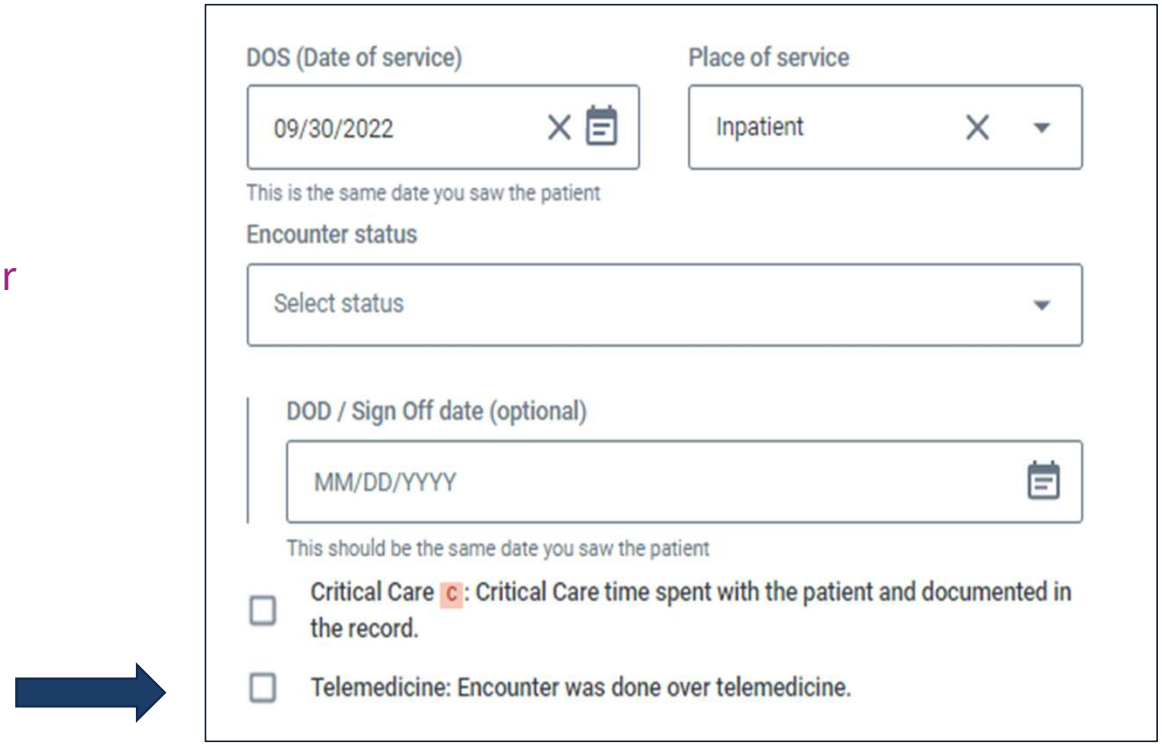
Telemedicine Reminders

- When entering visit into mySCP Care select the check box for Telemedicine: Encounter was done over telemedicine



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Telemedicine Physical Exam- Example

- General appearance (Constitutional)
- Visual exam of face, conjunctiva, lids (Eyes)
- Visual exam of mucosa (ENT/Mouth)
- Visual exam of respiratory effort: diaphragmatic movement, intercostal retractions, use of accessory muscles (Respiratory)
- Visual exam of the abdomen: appearance (Gastrointestinal)
- Gait, extremities with/without deformity, visualization of range of motion (Musculoskeletal)
- Orientation to time, place and person (Psychiatric)
- CN grossly intact and specify those that can be tested (Neurological)
- Inspection of skin (rashes, lesions, ulcers)—be sure to be clear about how much of the skin you can see (Skin)
- Add any other additional elements visualized

Initial and Subsequent Care Visits

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Initial and Subsequent Visit Requirements

Medical Decision Making

Date of Service

- Clearly documented
- Should match date entered in mySCP Care
- **Especially important for Nocturnist around midnight**

Place of Service

- Should match the orders in the EMR for that date
- Should match the place of service listed in mySCP Care

Chief Complaint

- What the patient is complaining of for that date
- Required, and can be inferred

History

- Medically appropriate

Physical Exam

- Medically appropriate

Diagnosis List

- Include all diagnosis impacting care or being managed
- Update daily
- Sequence in order of severity
- Include status of the problem (improving, resolved, worsening, no change etc.)

Assessment/ Plan

- Update daily
- Avoid cloning from previous day
- Document any work up ordered, reviewed or considered
- Document treatment and management options

Signature

Documentation Tips for HM

Initial Hospital Inpatient / Observation Care

Code	MDM
99221	Straightforward or Low
99222	Moderate
99223	High

Note:

- Initial Hospital Inpatient / Observation Care codes require:
  - Date of service and place of service
  - Performance and documentation of a medically appropriate and descriptive History and Exam
  - A detailed Medical Decision Making
  - Assessment and Plan:
    - Sequence diagnosis in order of severity
    - Include plan, status, and work-up with results for every problem being managed or impacting care

Documentation Tips for HM

Initial Observation Care

➢It is important to document **orders/place of service** for accurate billing of encounters performed

➢There are additional specifics required for Observation

- **Observation Orders** must be placed by the HM provider documenting the initial H&P
- If you are unable to place the observation order, then document the following on your H&P:
  - **"As clarification, the patient is placed in observation under my care."**

➢Refer to your hospital case management or admissions department for clarification of your hospital's Observation/Inpatient guidelines.

Documentation Tips for HM

Subsequent Hospital Inpatient / Observation Care

Code	MDM
99231	Straightforward or Low
99232	Moderate
99233	High

Note:

- Subsequent Hospital Inpatient / Observation Care codes require:
  - Date of service and place of service
  - Performance and documentation of a medically appropriate and descriptive History and Exam
  - A detailed Medical Decision Making
  - Assessment and Plan:
    - Sequence diagnosis in order of severity
    - Include plan, status, and work-up with results for every problem being managed or impacting care
    - Avoid copy and carrying forward prior notes without updating specific to current date of service

Documentation Tips for HM

Subsequent Hospital Inpatient / Observation Care

For each date of service:

Document all legitimate diagnoses being actively managed or impacting care on that date in order of severity.

- Document the status of the problem
  - Improving, resolved, uncontrolled, etc…
- Document the management of the problem
  - Medication changes/additions, continue current management, diagnostics ordered
- Sequence resolved diagnosis to the bottom of your problem list

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Subsequent Hospital Inpatient / Observation Care

Be careful when "copying and pasting" information (or Cloning) portions of a previous encounter!

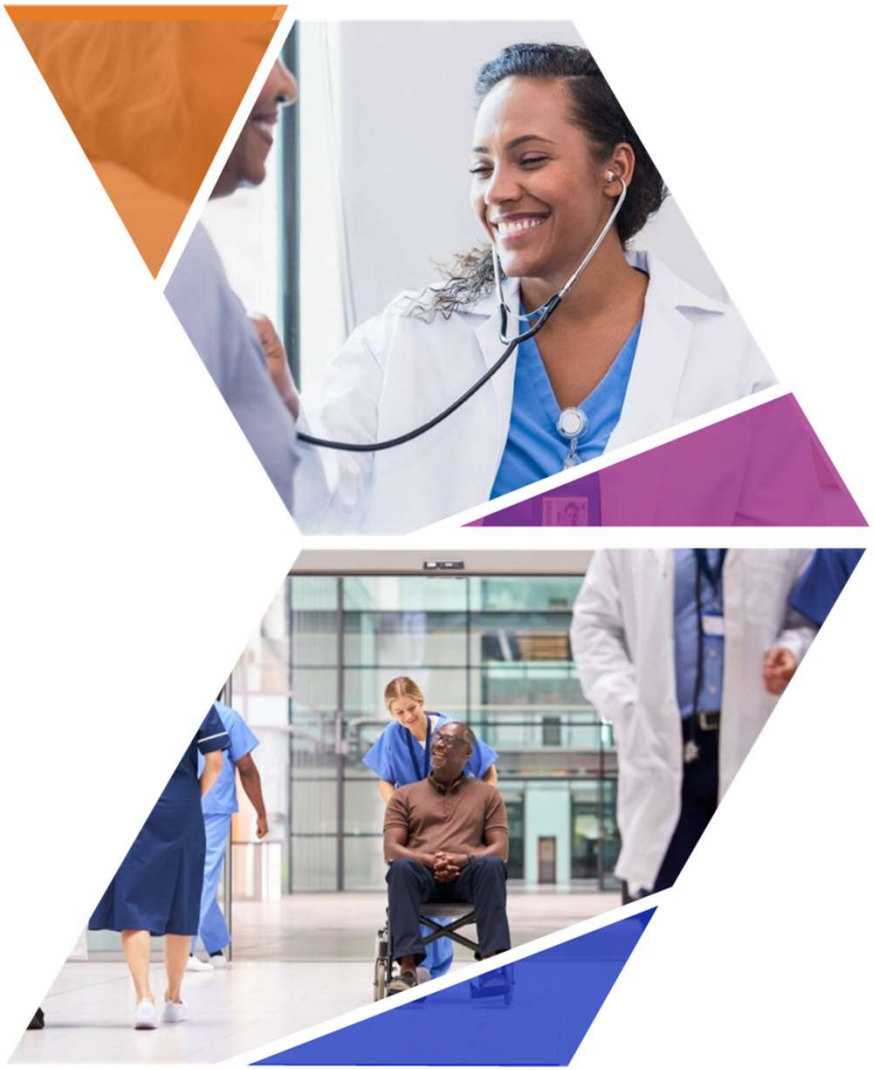
➢If you do copy forward information, please review, update and verify the accuracy of copied content!

- Assessment/Plan - ensure every encounter is updated daily
- Diagnoses
  - When copying forward diagnosis information, the status of the problem must be updated daily. If resolved, move to bottom of your problem list
  - Include the problem, evaluation date and management plan for every diagnosis to support medical decision making

➢Examples may include:

- "Chest pain, evaluated 09/26/2022, still having occasional pain, continue current management but add NTG SL per protocol"
- "Patient developed hyperkalemia today, evaluated 09/26/2022, DC potassium, check potassium level in AM"
- "COPD exacerbation, evaluated 09/26/2022, remains severely SOB, increase O2 to 3L NC, continue Nebulizer treatments"

Discharge Day Management



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Discharge Hospital Inpatient / Observation Care

- **Discharge Hospital Inpatient / Observation Care codes require:**
  - Date of service and place of service
  - Documentation of a face to face with the patient on day of discharge
  - Performance and documentation of a medically appropriate and descriptive final Exam as appropriate
  - An overview of the hospital course as appropriate
  - Instructions for continuing care
  - Patient or family counseling
  - Preparation of discharge records/ prescriptions
  - Referral Forms
  - Final diagnosis - sequence in order of severity
  - Total Time spent preparing the total Discharge in minutes (time ranges are not acceptable)

Code	Time
99238	30 minutes or less
99239	More than 30 minutes

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Discharge Hospital Inpatient / Observation Care cont.

➢Example of documented time and face-to-face encounter

45 minutes of time spent on discharge including examining patient providing discharge instructions, arranging follow up and documentation.

➢The discharge service must be billed on the date that the discharge was prepared, even if the patient did not go home on that date.

- Ride not available, bed not available, awaiting final test results

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Pronouncements, Transfers, & AMA Documentation Requirements

➢Pronouncements:

- Final examination to satisfy the "face-to-face"
- Time spent preparing the discharge (pronouncement, prep of death records, death summary)
- Any Critical Care service provided on the date of death

Note:

- Only the provider who pronounces the patient may bill for the Discharge service
- Completion of the death certificate alone is not sufficient for billing

➢Transfers (to other hospitals, swing bed, or SNF as well as pts leaving AMA):

- Be sure to document amount of time spent prepping pt when a face-to-face encounter is performed – this encounter type is also considered Discharge Day Management

Note:

- If pt left AMA and you did not have face-to-face time, please document that you did not see the patient to avoid being queried.

Critical Care

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What is Critical Care?

Critical Care is defined as an “illness or injury impacting one or more vital organ systems such that there is high probability of imminent, life-threatening deterioration in the patient’s condition”.

Hospital Medicine Clinicians may perform critical care services however, it is important that the documentation support the service provided.

Definitions of Critical Care (CC)

- Critical Care is the direct delivery by a Clinician of medical care for a critically ill or injured patient.
- A critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability of imminent or life-threatening deterioration in the patient’s condition at the time of service.
- The failure to initiate treatment on an urgent basis would likely result in sudden, clinically significant life-threatening deterioration in the patient’s condition.
- Critical care involves high complexity decision making to assess, manipulate and support vital system function(s) to treat single or multiple vital organ system failure and/or to prevent further life-threatening deterioration of the patient’s condition.

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Critical Care Codes

Critical care is a time driven code. A minimum of 30 minutes (excluding procedures) must be devoted exclusively to the patient. The actual time must be documented in the record, time ranges cannot be used. This time can be cumulative, but it cannot overlap any other patient care.

2 Critical Care Codes available:

➢99291- Critical care, evaluation and management of the critically ill or critically injured patient; first 30-103 minutes

➢99292 - Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (add-on code to 99291)

- Minimum of 104 minutes to bill the add on code

Total Critical Care Time	CPT
< 30 minutes	Billed as noncritical care (we still encourage clinicians to document their time)
30 - 103 minutes	99291
104 or more minutes	99291 and 99292

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Critical Care Time Includes:

All relevant medical care activities performed by the Provider directly related to the individual patient and time spent:

- ➢At the bedside **or** time spent elsewhere on the floor or unit as long as immediately available to the patient (in the nurses' station, with family members or surrogate decision makers when patient unable to participate in discussions)
- ➢Reviewing old records
- ➢Reviewing diagnostic results
- ➢Discussing the case with staff (within your hospital or at the receiving hospital if a transfer)
- ➢Discussing with family members (only if the patient is unable or clinically incompetent to participate in providing history or making management decisions)
- ➢Documenting in the medical record (also in **hospital medicine** this includes history & physical and progress notes)

You may also include time spent performing the following procedures since they are not separately billable when coding Critical Care:

- Cardiac output measures
- Pulse Oximetry
- Chest X-rays
- Blood Gases
- Gastric Intubation
- Temporary Pacing
- Ventilator Management
- Blood draw for specimen
- Venous Access/Arterial Puncture

Documentation Tips for HM

Coding and Billing for Critical Care

Clinician responsibility:

Document

✓the amount of time spent on critical care

✓the critical nature of the illness or injury

✓descriptions of all the Clinician's interval assessments

✓the patient's condition, any "impairments of organ systems" based on all relevant data available to the Clinician (i.e., symptoms and diagnostic data)

✓the interventions and the patient's response to treatment.

➢ ***Reminder** – Be mindful that you are not documenting more critical care time than possible in your shift**

Coder Responsibility:

- ✓ Confirm the Clinician's attestation of critical care by looking for documentation to support the patient's clinical condition at the time of service and the critical care treatment administered.
- ✓ Once critical care is validated, add up any critical care time documented throughout the DOS

Documentation Tips for HM

Critical Care: HM Coding Exceptions

- Critical Care may be billed **instead of** the Initial Hospital Care service if the patient complexity, delivery of care and documentation of time supports Critical Care at the time of admission.
- When Critical Care services are provided on a day where inpatient hospital E/M service was furnished earlier on the same date at which time the patient did not require critical care, **both** the critical care and the previous E/M service (Initial/subsequent visit) may be charged.
- It is not a place of service – Critical care can be performed in any location; the patient does not physically need to be in the ICU or CCU
- Multiple providers of **different groups** can bill for Critical Care on the same DOS as long as there is medical necessity.
- As of 2022, CMS allows Critical Care time performed by an NP/PA to be combined with Critical Care time performed by a Physician on the same DOS.
- Time spent by the NP/PA and Physician needs to be documented separately and must be non-duplicative, thus, it is critical that you document your individual time even if less than 30 minutes.

Documentation Tips for HM

Critical Care Documentation Reminders

SCP HEALTH

CRITICAL CARE DOCUMENTATION REMINDERS

Critical care: The failure to initiate treatment on an urgent basis would likely result in sudden, clinically significant life-threatening deterioration in the patient's condition. Documenting clinician must order the treating interventions.

Critical care time: Clinician must document the amount of the cumulative time spent on critically ill patients. Time does not reference only bedside care but also time reviewing test results, discussion with consultants, and documenting in the EMR. It does not include time spent on procedures, but those procedures that are commonly associated with critically ill patients. For example, you could write, "I provided 35 minutes of critical care time." Most electronic medical records have a method for you to easily chart this.

CONDITIONS COMMONLY ASSOCIATED WITH CRITICAL CARE:

- STEMI/Non-STEMI/Unstable angina
- Cardiac arrest
- Acute dysrhythmia
- Shock
- Hypotension
- Sepsis*
- Hypertension requires IV treatment
- Respiratory distress/failure
- Pulmonary edema
- Pulmonary embolus
- Hypoxia
- Altered mental status/coma
- Acute CVA/SAH
- Status epilepticus
- Meningitis
- Acute dysrhythmia without improvement after treatment
- Hyperkalemia/hyponatremia
- Rhabdomyolysis*
- Severe dehydration (adult/peds)
- Hyperemesis gravidarum
- DKA*
- Non-ketotic hyperosmolar hyperglycemia
- Hypothermia
- Perforated bowel/appendix
- Upper/lower GI bleed
- Ischemic bowel
- Toxic overdose
- Multi-system trauma
- Eclampsia

* Denotes commonly missed diagnoses

PROCEDURES ASSOCIATED WITH CRITICAL CARE:

- Intubation/BiPAP/C-PAP
- Central venous access
- Lumbar puncture
- Intra-osseous access
- Chest tube insertion
- Induced hypothermia
- Transcutaneous/venous pacemaker
- CPR

MEDICATIONS ASSOCIATED WITH CRITICAL CARE:

- Blood transfusions
- IV heparin/thrombolytics
- IV antiarrhythmics
  - Adenosine
  - Amiodarone
  - Beta blockers
  - Calcium blockers
- Vasopressors
  - Epinephrine/Norepinephrine
  - Dopamine/Dobutamine
  - Phenylephrine
- IV nitroglycerin
- IV anti-hypertensive agents
- IV Insulin
- IV antidotes (Digibind/Crofab/Fomepizole)

Documentation Tips for HM

Vital Organ System Failure – Possible Critical Care

- SHOCK - Cardiogenic, hypovolemic, Anaphylactic, Septic, Neurogenic, Spinal

- CIRCULATORY FAILURE
  - ACS/Acute MI/Unstable Angina
  - Cardiac dysrhythmias requiring intervention
  - Dissecting aortic aneurysm
  - Critical Burns
  - GI Bleed with hemodynamic instability
  - Drug ingestion with hemodynamic instability
  - Clinically acute/requiring urgent intervention:
    - Hypo/hypertension
    - Brady/Tachy-arrhythmias
    - Multiple system trauma

- CENTRAL NERVOUS SYSTEM FAILURE
  - Unstable cervical fracture
  - Coma; metabolic, toxic, anoxic, traumatic
  - Intracranial hemorrhage
  - Acute Stroke with altered mental status
  - Status Epilepticus

- RESPIRATORY FAILURE
  - Acute CHF with respiratory failure
  - Asthma with respiratory failure
  - PE with hemodynamic instability
  - Respiratory Failure with imminent intubation

- RENAL, HEPATIC, METABOLIC FAILURE
  - DKA with hemodynamic instability

Documentation Tips for HM

Medications and Interventions: Possible Critical Care

Medications via IV:

- Atropine
- Bicarb
- Heparin / Thrombolytics
- Antiarrhythmics
- Vasopressors
  - Dopamine/ Dobutamine
  - Epinephrine/ Norepinephrine
- Nitroglycerine Drip
- Antihypertensive agents
- Magnesium Sulfate
- Mannitol
- Narcan

Interventions:

- Bi-Pap (bi-level positive airway pressure)
- C-Pap (continuous positive airway pressure)-not for Chronic Sleep Apnea
- Intubation
- Transcutaneous Pacemaker
- Defibrillation
- Cardioversion
- Fluid/Blood Resuscitation for frank shock/burns
- Chest tube for hemothorax /pneumothorax
- Initiate ventilator in the Unit

*some of these are separately billable procedures and must be deducted from total Critical Care time

Documentation Tips for HM

Critical Care Procedures

Commonly performed and associated but separately billable in addition to Critical Care:

	CPT Code
Endotracheal Intubation	31500
Cardiopulmonary Resuscitation	92950
Chest Tube Insertion and Thoracentesis	32551, 32002
Lumbar Puncture	62270
Central Line Insertion	36556
Intra-osseus Access	36680

*Remember: Time spent performing separately billable procedures must be deducted from total Critical Care time!

Documentation Tips for HM

Critical Care Documentation Example

"45 minutes of Critical Care was provided in order to assess and manage the high probability of imminent or life-threatening deterioration of cardio-respiratory status requiring vasodilator support and pending intubation. Critical Care time noted does not include the time spent performing separately billable procedures."

Additional Patient Care Services

SCP HEALTH

Documentation Tips for HM

Advance Care Planning: Time based code

Advance Care Planning (ACP) is a voluntary, face-to-face service between a physician or other qualified health care professional (QHP) and a patient, family member, caregiver, or surrogate to discuss the patient's health care wishes if they become unable to make their own medical decisions.

As part of this discussion, you may talk about advance directives **with or without** helping a patient complete legal forms. An advance directive appoints an agent and records a patient's medical treatment wishes based on their values and preferences. You can generally find them on your state attorney general's office website.

Examples of advance directives include:

- Living wills
- Medical orders for life-sustaining treatment
- Health care proxy
- Durable power of attorney for health care
- Psychiatric advance directives

It is a **time-based service**, that requires a time statement describing the aggregate total face-to-face time of the NP/PA and/or physician while the discussion takes place.

- ✓ Must be reported for each DOS when performed. Cannot be reported as a combined service over the entire episode of care.
- ✓ Less than 16 minutes of face-to-face discussion time cannot be reported separately.
- ✓ ACP time must be separate from time spent doing other things, like taking the history or doing other E/M work
- ✓ **ACP work cannot be reported with critical care.**

Code	Total Time
99497	16 minutes up to 30 minutes
99498	Each additional 30 minutes (starting at 46 minutes)

Documentation Tips for HM

Advance Care Planning: Documentation Requirements

Documentation should include:

- Who was present during the encounter, including the names of those present
- The content and medical necessity
  - What was discussed and any follow up as appropriate
  - Why are they making the decision
  - The understanding of the illness, spiritual factors
- If any forms were completed and the content of any advance directives
- Any change in health status or health care wishes if the patient becomes unable to make their own decisions
- The time spent discussing ACP during the face-to-face encounter

A statement like the following might adequately describe the Advance Care Planning service for reimbursement purposes:

"I spoke with the patient and her daughter, Amanda, today regarding advance directives and end of life planning. Due to the progression of the patient's heart failure she wishes to be made DNR. I have updated the orders to change the patient to DNR. She concluded that she would like to complete ACP forms. I spent 20 minutes of face-to-face time discussing ACP."

Documentation Tips for HM

Tobacco Cessation Counseling: Time based code

- Cigarette smoking is a major modifiable health risk factor in the United States.
- Tobacco treatment is a CMS/JCAHO MIPS/Core Measure and statistics about performance are reported for clinicians and hospitals.
- Providers are strongly encouraged to discuss options for quitting with patients and to document those conversations when they occur for quality reporting and reimbursement.
- Two Smoking Cessation attempts per year are covered, and each attempt may include a maximum of 4 intermediate or intensive sessions with a total benefit covering 8 sessions in a 12-month period.

Code	Total Time
99406	Greater than 3 minutes
99407	Greater than 10 minutes

- **Documentation in the medical record must clearly represent:**
  - That the patient is alert and competent
  - The patient's tobacco dependence (cigarettes, smokeless)
  - Your counseling session with the patient, including the **Treatment Recommended** and the **Patient's Response** to counseling
  - The **Total Time** in minutes spent performing the service (**not a range**)

- **Suggested Tobacco Cessation Counseling Tips**
  - Ask about tobacco use at every visit
  - Discuss health risks of continued tobacco use
  - Advise tobacco users to quit
  - Discuss rewards/benefits of tobacco cessation
  - Assess the willingness to attempt quitting
  - Assist the patient with methods for quitting
  - Arrange for follow-up contact as appropriate

Example: "Patient was counseled on smoking cessation for 6 minutes, RX for nicotine patch offered, patient refuses and states does not want to quit."

NP/PA Documentation Requirements

Attestations

Split Share- 2024 Attestation Update

- **January 2024 CMS Updates:** The medical record should indicate which practitioner performed the substantive portion of the E/M visit. **For 2024, the substantive portion is defined as:**
  - **Time Spent**: more than half of the total time spent by the physician and NP or PA performing the shared visit

    OR
  - **Medical Decision Making**: performing the substantive portion of the medical decision making
- **The substantive portion of the MDM requires the billing practitioner to:**
  - ✓ Make or approved the management plan for the number and complexity of problems addressed at the encounter
  - ✓ Take responsibility for that plan with its inherent risk of complications and/or morbidity or mortality of patient management
  - **Note:** Any independent interpretation of tests and discussion of management plans must be personally performed by the billing practitioner
- **For time-based codes**, (such as critical care and discharges) the practitioner who performs more than half of the total (non-duplicated) time spent on the visit will receive credit for the entire time-based service.
  - **Time** spent by NP/PA and the physician needs to be separately documented.
  - **Critical Care Time** guidelines allow for critical care time to be shared between the providers to arrive at the final critical care code.

Split Share – 2024 Attestation Update

Evaluation and Management (E/M) Visits (excluding time services, i.e., critical care or HM discharges) – If the physician performs the substantive portion of the MDM and documents the recommended information below, the E/M visit will be billed under the physician.

The following specific documentation is recommended if you are collaborating with an NP/PA in direct patient care:

✓ If performed, personal documentation of **ONE** of the following by the **physician**:

- **Statement** that you **made/approved the management plan** and **take responsibility** for the patient management.

OR

- **Medical Decision Making** – to include patient complaint, differential diagnoses, the work-up performed for differential diagnoses and medical necessity by the physician

✓ Document your review and whether you agree with NP/PA's documentation, treatment plan, and medical decision making

✓ A statement indicating whether you had face-to-face time with the patient

Examples of acceptable physician attestations during NP/PA collaboration:

" I personally made/approved the management plan for this patient and take responsibility for the patient management. I reviewed the NP/PA's documentation, agree with the NP/PA's assessment, and I had face to face time with the patient."

Split Share – 2024 Attestation Update

If any **independent interpretation** of tests or **discussion of management plans** are performed by the physician, then the attestation should also include the physician's independent interpretation and/or details of the discussion/consultation.

- *"I personally made/approved the management plan for this patient and take responsibility for the patient management. I reviewed the NP/PA's documentation, agree with the NP/PA's assessment, and I had face to face time with the patient. I **independently interpreted** the EKG, shows NSR of 72, No ST segments, or T wave changes."*
- *"I personally made/approved the management plan for this patient and take responsibility for the patient management. I reviewed the NP/PA's documentation, agree with the NP/PA's assessment, and I had face to face time with the patient. I **discussed** the patient with cardiology. They recommend cardioversion in the ED and follow-up with their office."*
- *"I reviewed the NP/PA's documentation, agree with the NP/PA's assessment, and I had face to face time with the patient. **My MDM:**"*

  64-year-old female with CP and vital signs, B/P 140/90. Old records indicate a history of coronary artery disease.

  DDX: ACS, pneumonia, and pneumothorax

  EKG Interpreted by me - shows normal sinus rhythm of 72 no ST segments or T wave changes

  Troponin normal, d-dimer elevated, glucose 210

  CXR normal

  CTA no evidence of pulmonary embolus

  Impression: Chest pain unclear etiology

  Discussed admission and plan of care with Emergency physician

  Plan is to admit to Telemetry

Split Share – 2024 Attestation Update

Time-based services (such as critical care and discharges) – the practitioner who performs more than half of the total **(non-duplicated)** time spent on the visit will receive credit for the entire time-based service.

Critical Care Time spent by NP/PA and the physician **needs to be separately documented**. 2022 guidelines allow for critical care time to be shared between the clinicians to arrive at the final critical care code. Thus, it is critical that you document your individually dedicated critical care time. Document your time spent even if less than 30 minutes.

- ✓ **The physician must still document a statement which states:**
  - The total time the physician personally spent providing critical care.
  - How the patient was critically ill when the physician saw the patient.
  - What made the patient critically ill; and the nature of the treatment and management provided by the physician.

Example of acceptable **critical care** physician attestation during NP/PA collaboration:

"Patient developed hypotension and hypoxia; I spent 45 minutes of critical care time while the patient was in this condition, providing fluids, pressor drugs, and oxygen. I reviewed the NP/PA's documentation and agree with the assessment and plan of care."

Example of acceptable **discharge** physician attestation during NP/PA collaboration:

"I reviewed the NP/PA's documentation and agree with the NP/PA's assessment and plan of care. I had face to face time with the patient. I spent 40 minutes discharging the patient."

Split Share – 2024 Attestation Update

Additional tips for Collaboration with NP/PA's:

- ✓ An important distinction to note is that a **"co-signature" is not the same as an attestation**. Many EMRs have a process in place that requires all NP/PA charts to be co-signed by the physician. However, this does not mean that all charts will necessarily be attested. This simply means that the physician reviews NP/PA documentation and co-signs the chart without seeing the patient. Under this scenario, the chart would be billed under the NP/PA.
- ✓ Facilities that have NP/PA's working in the department may have **facility-specific criteria** that is more stringent on what is described above. Please coordinate with your Medical Director with any related questions.
- ✓ You will continue to receive queries (Attestation and/or Service Category Query) via mySCP Care for those split/share encounters without evidence of substantive portion of treatment documented.

Reference the link below for more information:

- **ACEP's Shared Services FAQs**

  https://www.acep.org/administration/reimbursement/reimbursement-faqs/Shared-Services-FAQ#:~:text=Specifically%2C%20for%20CY%202024%2C%20for,making%20as%20defined%20by%20CPT

- **CMS – MPFS Final Rule 2024 – page 468**

  https://public-inspection.federalregister.gov/2023-24184.pdf

Documentation Tips for HM

Split-Shared vs Independent Visits

Split Shared

- PHYSICIAN face-to-face AND attestation is required
- In the absence of F2F attestations, MD/DO co-signature may be required

Independent

- Billed under the NP/PA's provider number
- No PHYSICIAN face-to-face or attestation is required
- MD co-signature may be required

Note: Coding will adjust the billing provider at time of their secondary review to match the documentation submitted

Teaching Physician Services

SCP HEALTH

Documentation Tips for HM

Teaching Physician Services – Documentation Scenarios

- The teaching physician must document:
  - That he/she personally saw the patient
  - Personally performed critical or key portions of the service
  - Participated in the management of the patient.
- The teaching physician's note should reference the resident's note.
- For payment, the composite of the teaching physician's entry and the resident's entry together must support the medical necessity of the billed service and the level of service billed by the teaching physician.

Minimally acceptable documentation in this scenario:

- **Initial Visit:**

  "I saw and evaluated the patient. I reviewed the resident's note and agree, except the clinical picture is more consistent with pericarditis than myocardial ischemia. Will begin NSAID's."

- **Initial or Subsequent Visit:**

  "I saw and evaluated the patient. Discussed with resident and agree with resident's findings and plan as documented in the resident's note."

- **Subsequent Visit:**

  "See resident's note for details. I saw and evaluated the patient and agree with the resident's findings and plan as documented in the resident's note."

  "I saw and evaluated the patient. Agree with resident's note but lower extremities are weaker, now 3/5; MRI of L/S spine today."

Documentation Tips for HM

Minor Procedures Performed by Residents

Procedures that take only a few minutes (five minutes or less) to complete, e.g. simple suture, and involve relatively little decision making once the need for the procedure is determined:

- The teaching physician must be present for the entire procedure in order to bill for the procedure

Documentation Tips for HM

Teaching Physician Services – Unacceptable Documentation

- "Agree with above.", followed by legible countersignature or identity;
- "Rounded, Reviewed, Agree." followed by legible countersignature or identity;
- "Discussed with resident. Agree." followed by legible countersignature or identity;
- "Seen and agree." followed by legible countersignature or identity;
- "Patient seen and evaluated.", followed by legible countersignature or identity;
- A legible countersignature or identity alone.

Documentation Tips for HM

Medical Students

An individual who participates in an accredited educational program (e.g., a medical school) that is not an approved GME program.

CMS has approved the use of student documentation to decrease the documentation burden on the NP, PA, or physician.

- This applies to all students (medical, NP, and PA)
- The physician, NP, or PA must personally **perform (or re-perform)** the physical exam and medical decision-making activities however, re-documentation is not required.
- The student attestation below must be used as written.
  - "I was physically present during the student's evaluation of the patient. I personally re-performed the physical exam and medical decision-making activities. I reviewed and agree with the student's documentation and/or findings including history (CC, HPI, ROS, PFSH), physical exam, and medical decision making except as documented below. "

Procedures and students from a billing perspective:

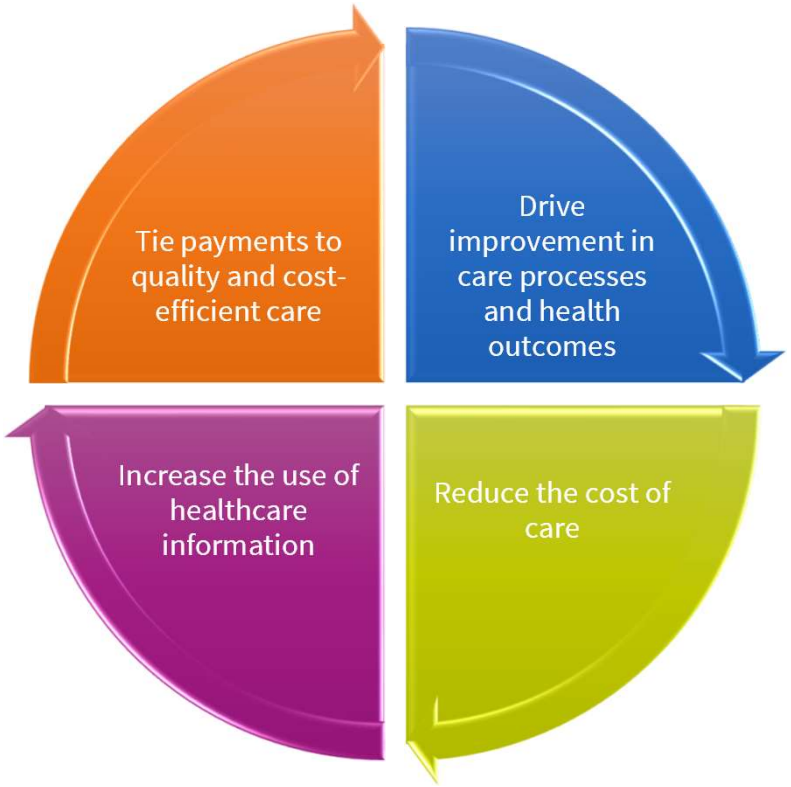
- **Billable**
  - If a student does a procedure, the same procedure **must be repeated by the supervising provider to make the procedure billable**
- **Non-billable**
  - If the student does a procedure and it is **not repeated by the supervising provider, the procedure is non-billable.**

Merit Based Incentive Payment System

SCP HEALTH

Documentation Tips for HM

Merit Based Incentive Payment System



2024 Hospital Medicine MIPS

- Screening for Social Drivers of Health
- Advance Care Plan or Surrogate Decision Makers
- Documentation of Current Medications in Medical Record
- Heart Failure:
  ACE/ARB/ARNI Therapy for LVSD ≤ 40%
  Beta Blocker Therapy for LVSD ≤ 40%
- t-PA Utilization for Ischemic Stroke
- Screening for Tobacco Use and Cessation
- Screening for High Blood Pressure and Follow Up
- Diabetes: Hemoglobin A1c Poor Control

Documentation Tips for HM

Common MIPS Measures

Screening for Social Drivers: 18+

- Documentation should acknowledgement that the screening was performed, and any areas identified

  Sample phrase:

  The patient was screened for social drivers of health including food insecurity, housing instability, transportation needs, utility difficulties and interpersonal safety.

  Areas identified for concern are:

  <list area/circumstance>

  None

Advance Care Plan or Surrogate Decision Makers: 65+

- The patient's advance care plan and code status should be documented upon admission in the H&P
- Any subsequent clinicians will acknowledge in mySCP Care that it is present in the EMR

Documentation of Current Medications: 18+

- Within the EMR there should be documentation of the patient's prior to arrival medications. The list should include dose, frequency, and route
- The clinician can attest to documenting, updating or reviewing a list of all known prescriptions, over the counter medications and supplements

Documentation for HM

Diagnosis Specific Measures

Heart Failure Therapy for LVSD ≤ 40%

- Applies to discharges
- **ACE/ARB/ARNI** Therapy prescribed or currently being taken
- **Beta Blocker Therapy** prescribed or currently being taken
- If not prescribed document contraindication

t-PA Utilization for Ischemic Stroke

- **IV Thrombolytic therapy** initiated within 4.5 hours of time last known well
- If not initiated documentation should include rational for not administrating t-PA

Documentation Tips for HM

Observation/Outpatient Measures

Preventive Care and Screenings

Tobacco Use and Cessation

Documentation should include either:

- The patient was screened for tobacco use and received cessation counseling
- The patient is non tobacco user

High Blood Pressure and Follow Up

Documentation should include:

- The patient was screened for high blood pressure and recommended follow up plan
- Systolic BP 120-139 and Diastolic BP 80-89 require referral to alternate/primary care
- Systolic BP ≥ 140 and Diastolic BP ≥ 90 required referral between 1 day and 4 weeks

Diabetes: Hemoglobin A1C Poor Control

- Most recent HbA1C is documented
- A1c drawn within 1 year from admit can be used if current A1c is not drawn

Recap, Reminders, and Provider Feedback

SCP HEALTH

Documentation Tips for HM

Recap & Reminders

➢ **All encounters must include documentation of a:**

- Chief Complaint
- Medically appropriate History (HPI, PFSH, ROS) and Physical Exam
- Descriptive medical decision making

➢ **Total time MUST be documented for:**

- Critical Care
- Prolonged Services
- Tobacco Cessation
- Advance Care Planning
- Discharge Activities

➢ **Date of Service:**

Include your date of service for every encounter to avoid confusion and potential missed billing.

- It is sometimes confused with dictated date, transcribed date, typed date, authenticated date

➢ **Progress notes:**

Make sure that each DOS is unique

Update Dx status/plan as appropriate

Avoid “cloning” of same information

➢ **Timeliness:**

Documentation completion – same date

Responsiveness to administrative requirements

Documentation Tips for HM

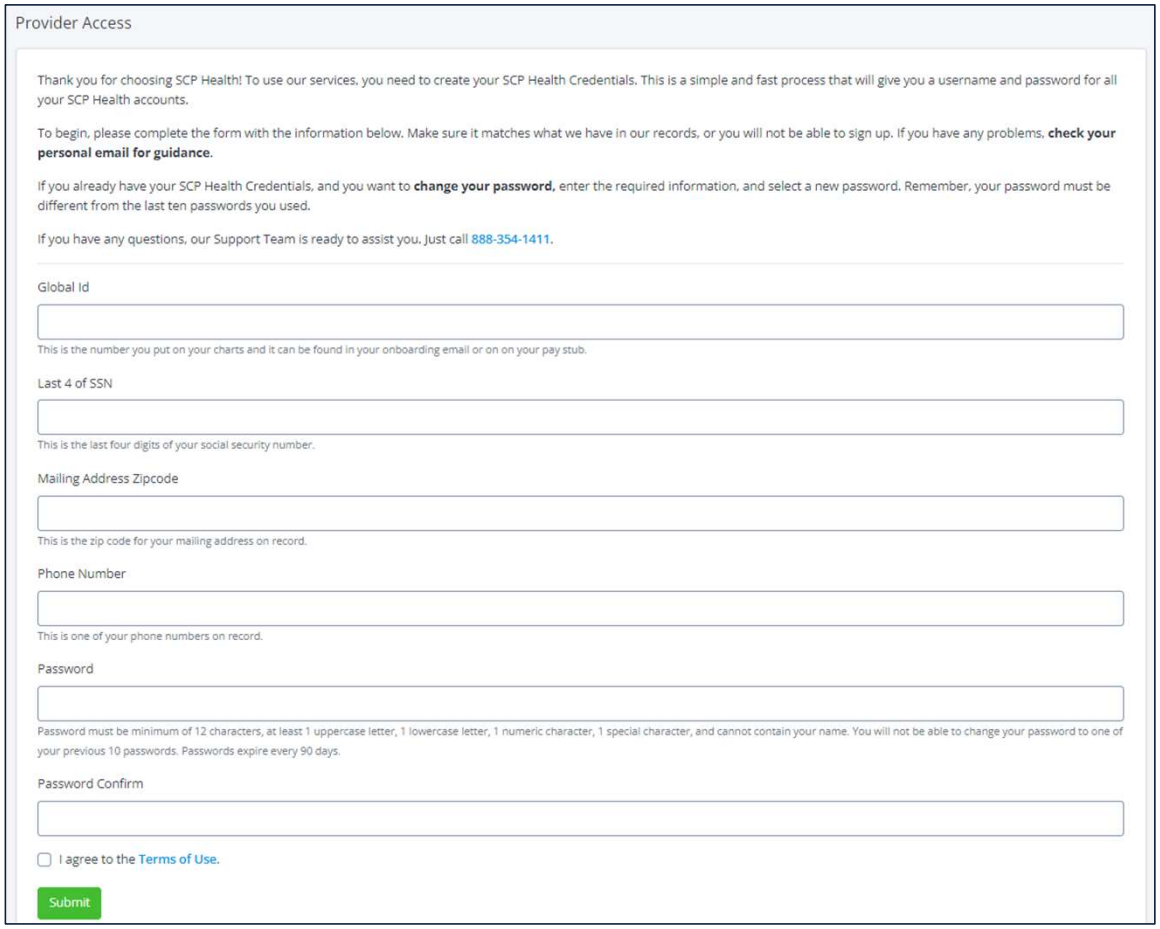
Provider Feedback

- Provider performance reviewed on a monthly basis.
- Facility Report Cards provided to HM leadership and Medical Directors/Facility Site Leads on a monthly basis.
- Clinicians will receive educational email notifications.

Provider Portal & mySCP Care

SCP HEALTH

SCP Account Creation



Provider Access

Thank you for choosing SCP Health! To use our services, you need to create your SCP Health Credentials. This is a simple and fast process that will give you a username and password for all your SCP Health accounts.

To begin, please complete the form with the information below. Make sure it matches what we have in our records, or you will not be able to sign up. If you have any problems, **check your personal email for guidance**.

If you already have your SCP Health Credentials, and you want to **change your password**, enter the required information, and select a new password. Remember, your password must be different from the last ten passwords you used.

If you have any questions, our Support Team is ready to assist you. Just call 888-354-1411.

Global Id

This is the number you put on your charts and it can be found in your onboarding email or on on your pay stub.

Last 4 of SSN

This is the last four digits of your social security number.

Mailing Address Zipcode

This is the zip code for your mailing address on record.

Phone Number

This is one of your phone numbers on record.

Password

Password must be minimum of 12 characters, at least 1 uppercase letter, 1 lowercase letter, 1 numeric character, 1 special character, and cannot contain your name. You will not be able to change your password to one of your previous 10 passwords. Passwords expire every 90 days.

Password Confirm

I agree to the Terms of Use.

Submit

To create your SCP account, access the website below:

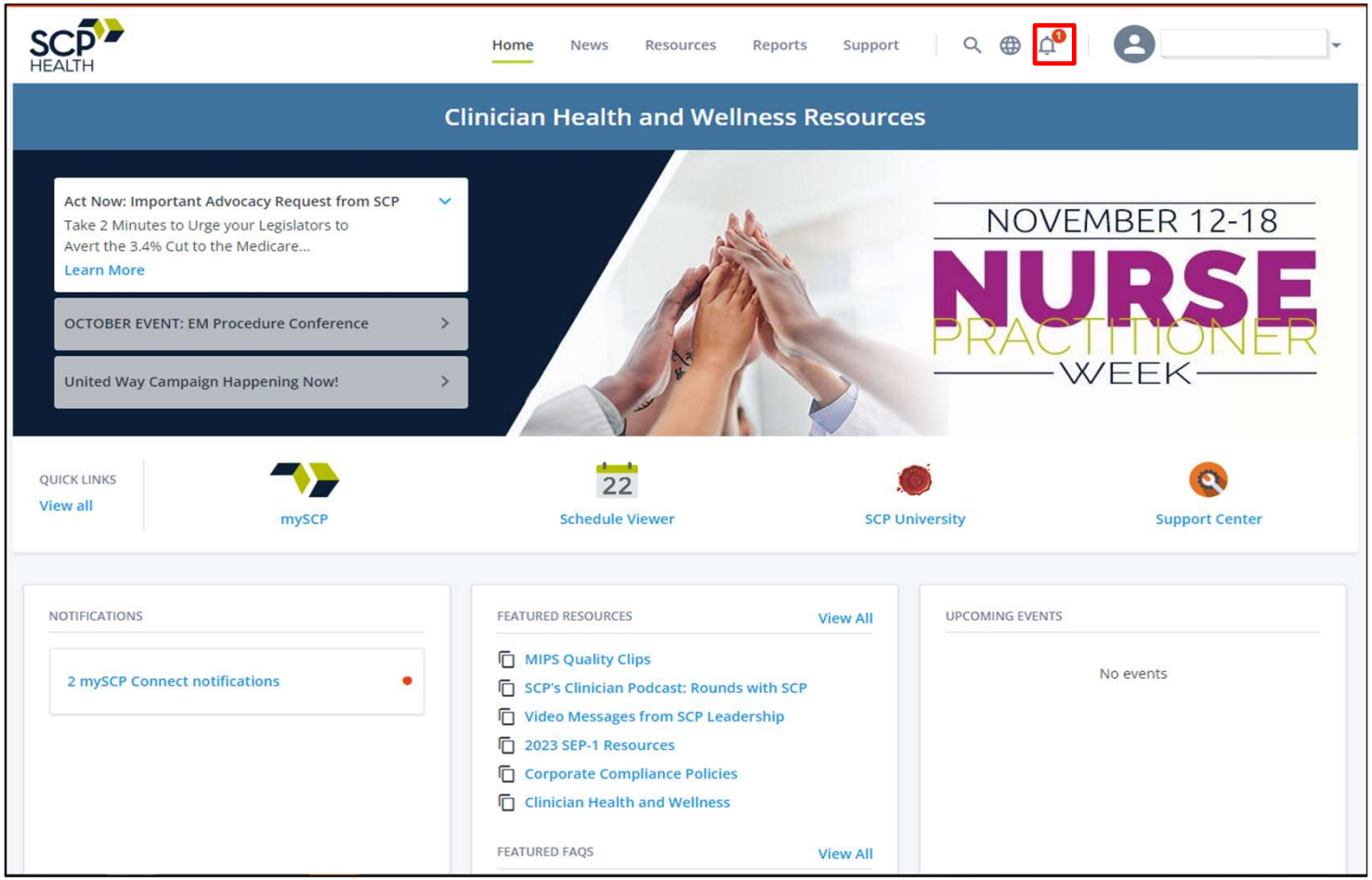
https://www.myscphealth.com/login-help/provider-access

Complete the information below:

- Your global ID was sent via email, or you can contact your SCP Documentation Specialist or Practice Manager
- Last 4 of SSN
- Mailing Zipcode
- Phone Number

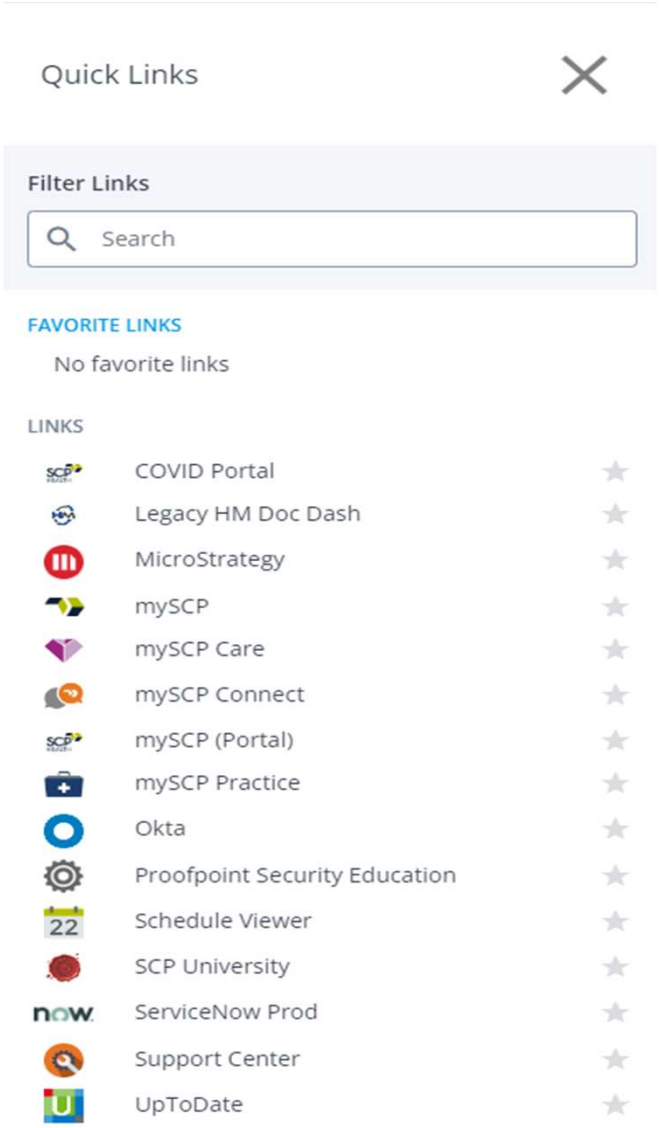
Your username will be your firstname.lastname

Provider Portal



www.myscphealth.com

Need help logging in? Navigate to www.myscphealth.com/login-help



Provider Portal Quick Links

SCP University

Educational videos

mySCP Care/Connect/Practice

SCP Product Suite used for encounter entry, secure messaging, and scheduling

UpToDate

Evidence based resources to support your clinical decisions and inform your research

Tip: Select the ★ to favorite and add to your quick links!

SCP University

➢Click the SCP University icon on your Provider Portal homepage to get started.

SCP University

➢Click on the “Content Library” link

➢Search “HM Physician Orientation”

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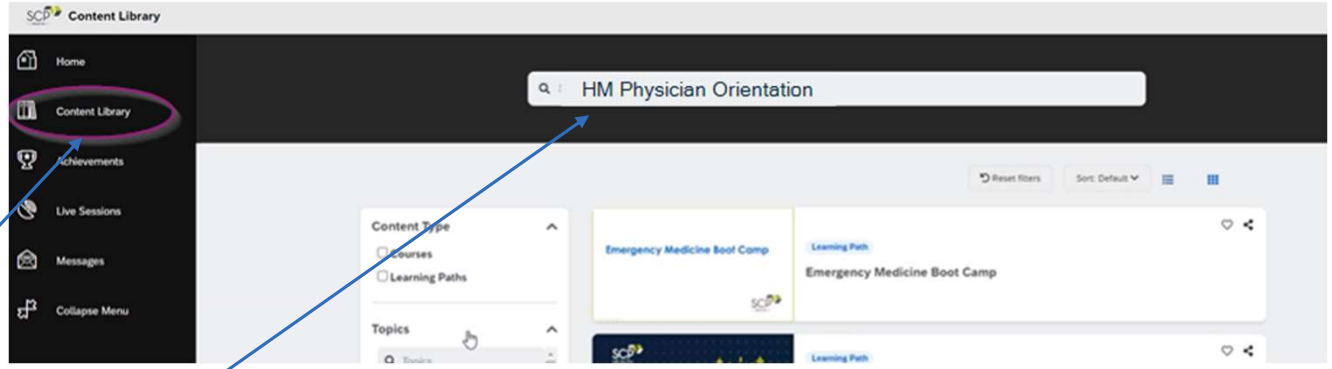
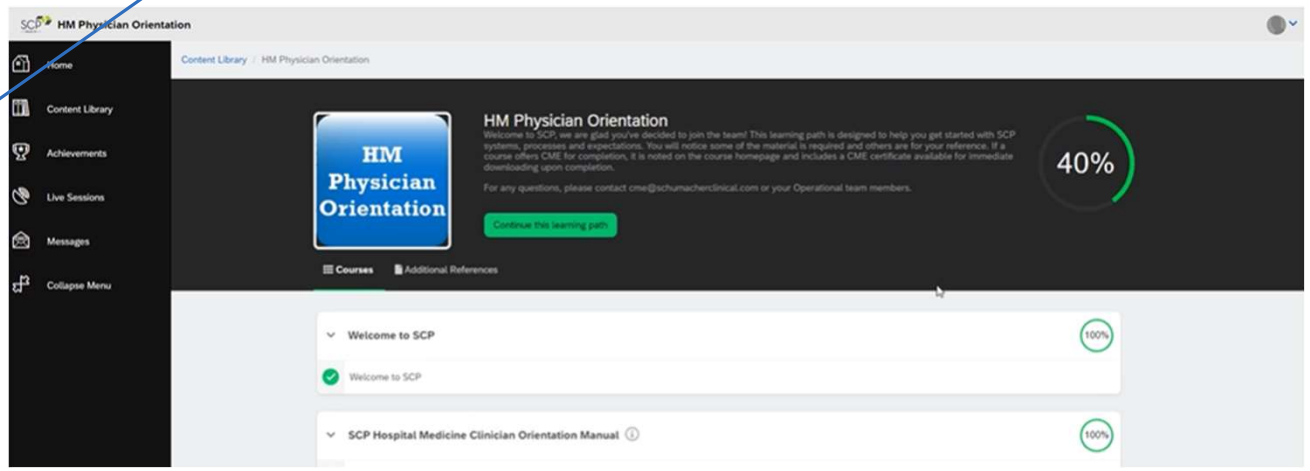
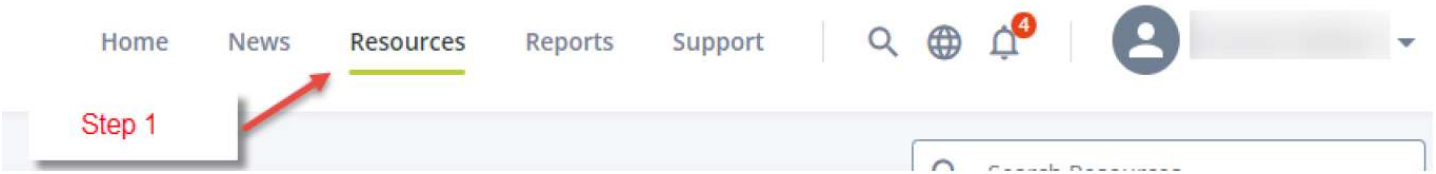


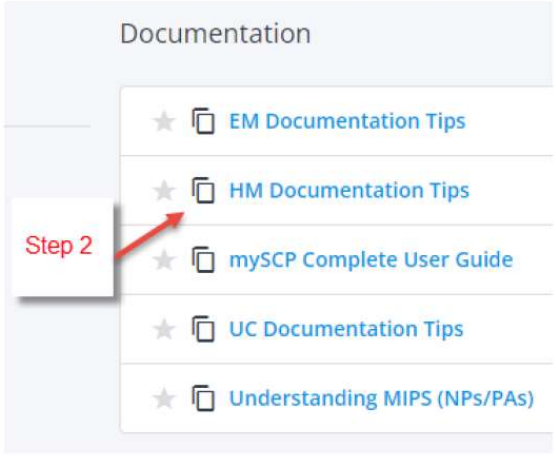


Other Resources

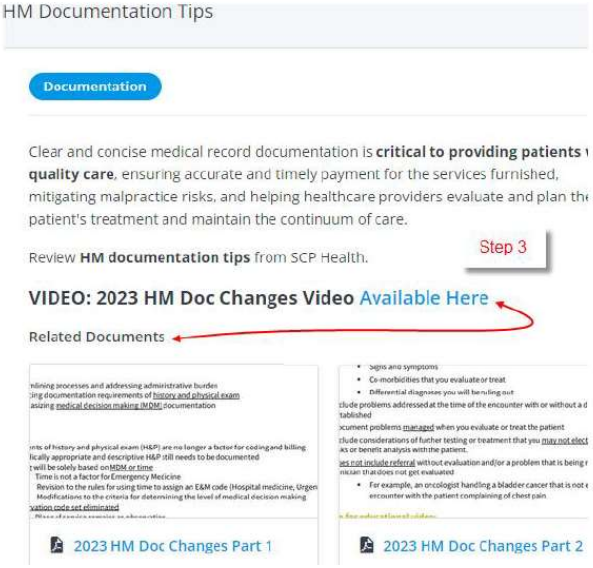
Step 1: Once logged into the clinician portal, click on ‘Resources’.



Step 2: Select HM Documentation Tips.



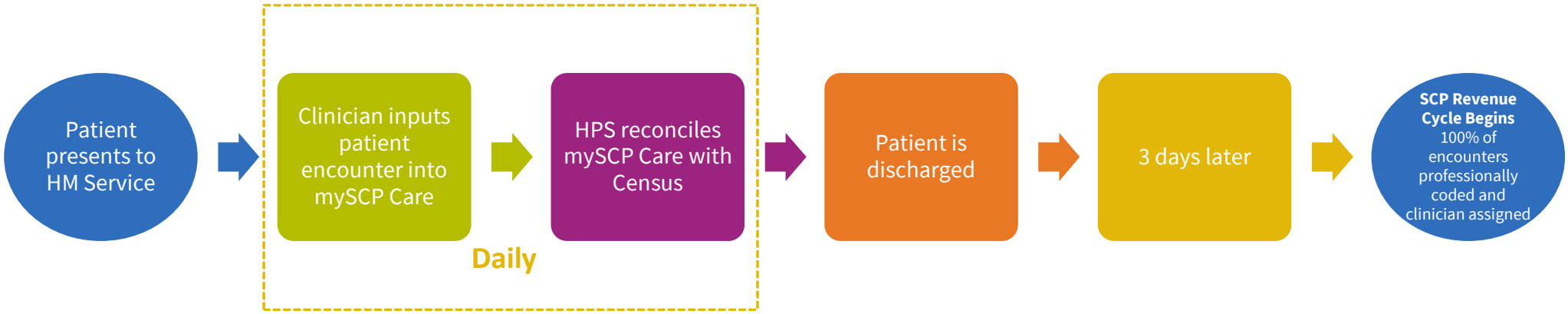
Step 3: Select the video or any tip listed on page



mySCP Care App
Capturing Encounters & Expectations

mySCP Care

Process Overview

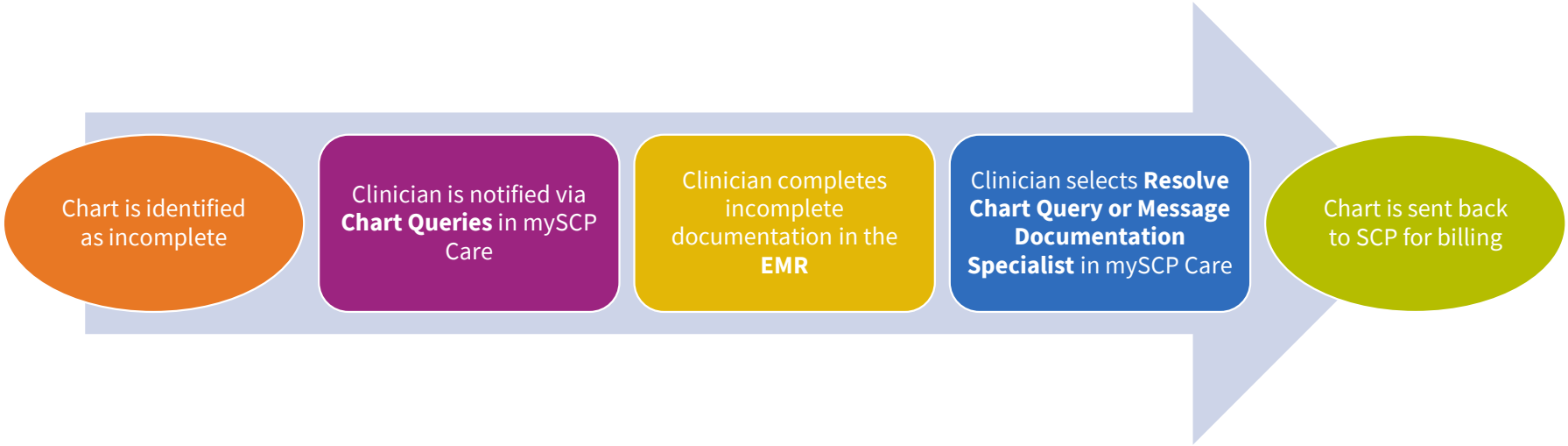


Important: Clinician must complete all documentation and enter encounters prior to end of shift

mySCP Care is not a billing software. It is a practice management solution used to capture encounter level detail

mySCP Care

What happens if chart is incomplete?



Documentation Tips for HM

mySCP Care: Clinician Expectations

- Clinician is **responsible** for **entering all new patients** in mySCP Care

- Clinician **must enter** in **all encounters** for each patient **prior to end of shift**.

- Clinician is **required enter all documentation, including the history, physical, and medical decision making in the EMR** at their facility.

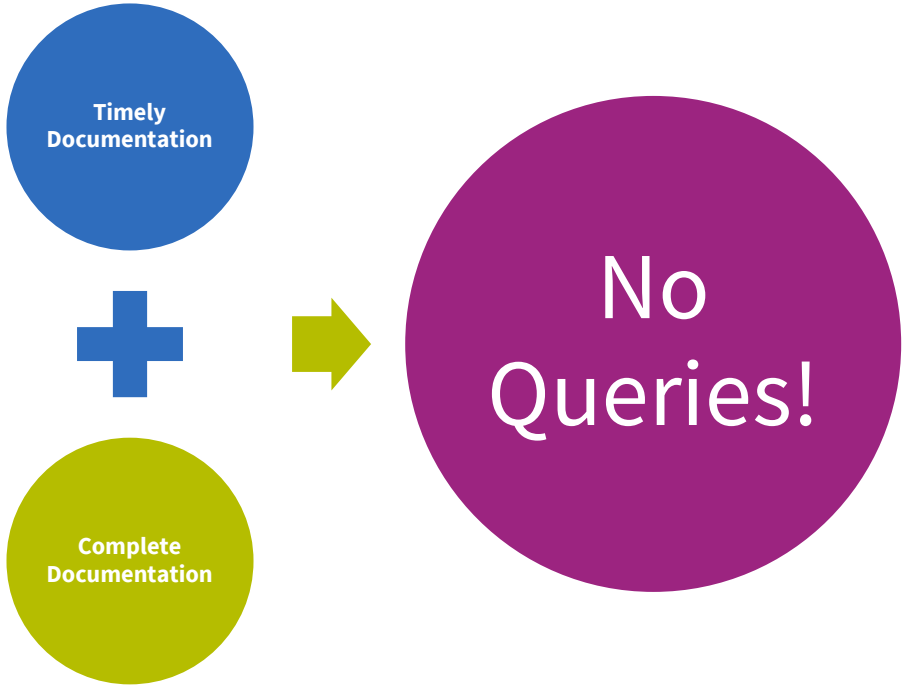
- Incomplete documentation (queries) will be routed to the clinician through the app via **Chart Queries**
  - Clinician must address **all** incomplete documentation in the **EMR.**
  - Clinician **must communicate** when it is resolved (via mySCP Care).

- If working with an NP/PA, the clinician who authored the original note will enter the patient in mySCP Care. The physician will be selected as supervising by the NP/PA and the physician will be sent those encounters to review.

Delay of documentation may result in the return of an incomplete chart due to timing of process.

Documentation Tips for HM

mySCP Care: Queries



mySCP Care

Queries

Documentation Missing

- Diagnosis Missing
- Physical Exam Missing
- H&P Missing
- Progress Note Missing
- Discharge Summary Missing

ICD10 Clarification

- Displaced or non-displaced fracture
- Abdominal pain laterality

Date of Service Clarification

- Documentation either does not contain a DOS or a DOS clarification is needed
- DOS should be listed as the date the provider first saw the patient for those visits that cross over midnight

Admit Order/Place of Service Clarification

- Applied when the admit order is missing OR
- Admit order is present, but does not match the place of service indicated within your note

HM Obs Statement Needed

- Observation orders must be placed by the admitting HM clinician, this applies to bridge orders from the ED.
- **"As clarification, the patient should be placed in observation services under my care.**

mySCP Care

How to Get Started

mySCP Care can be accessed via a mobile app or a web browser.
Please login using your SCP Health credentials.

Mobile App available today on IOS and Android

Download on the App Store

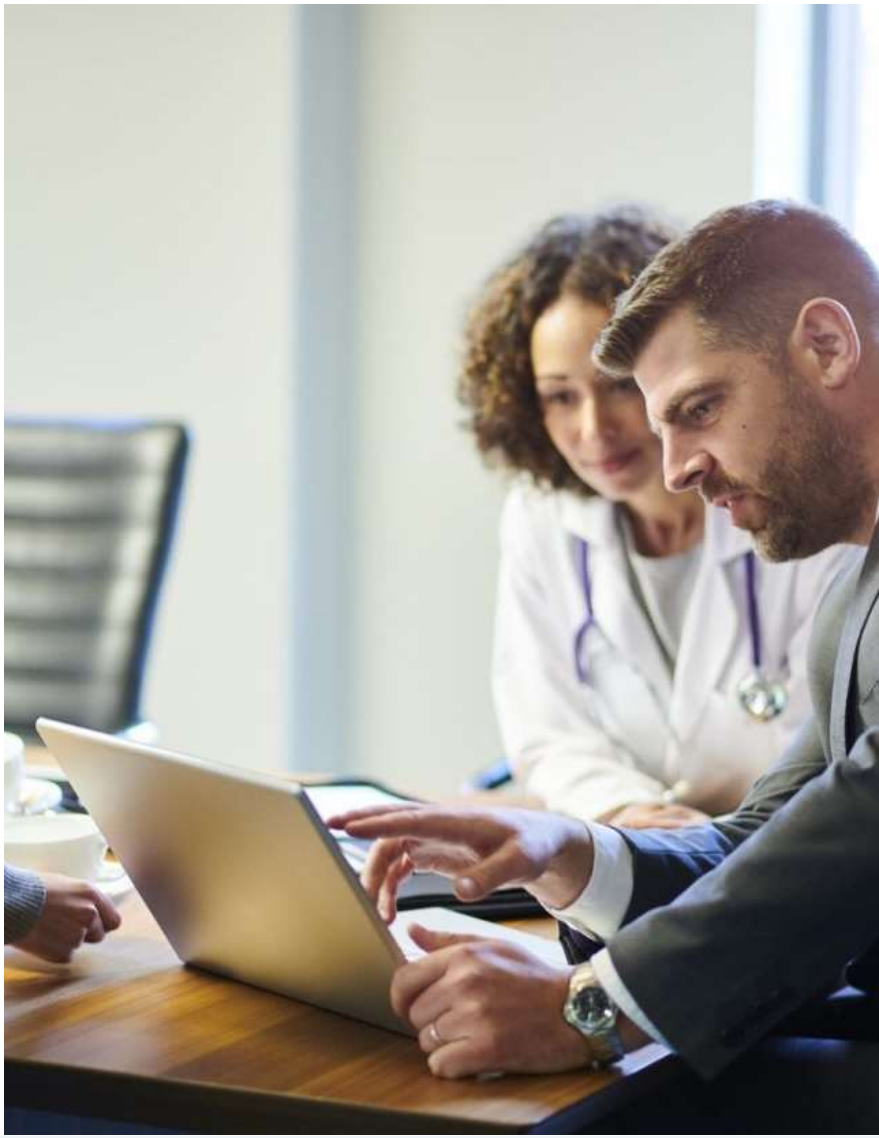
GET IT ON Google Play

Web version should be accessed via **Care.myscp.com**

Note: please make sure your browser is updated to its latest version; we recommend Chrome.

mySCP Support

- If you experience issues or have questions, please reach out to your facility **Hospital Practice Manager (HPM) and/or Hospital Practice Specialist (HPS), for assistance.**
- If you need **additional support** or have a feature suggestion, please email mySCPCareSupport@scp-health.com
- **Access issues:** please go to https://www.myscphealth.com/login-help/provider-access and reset your password.



Documentation Tips for HM

mySCP Care App Demonstration

mySCP Care

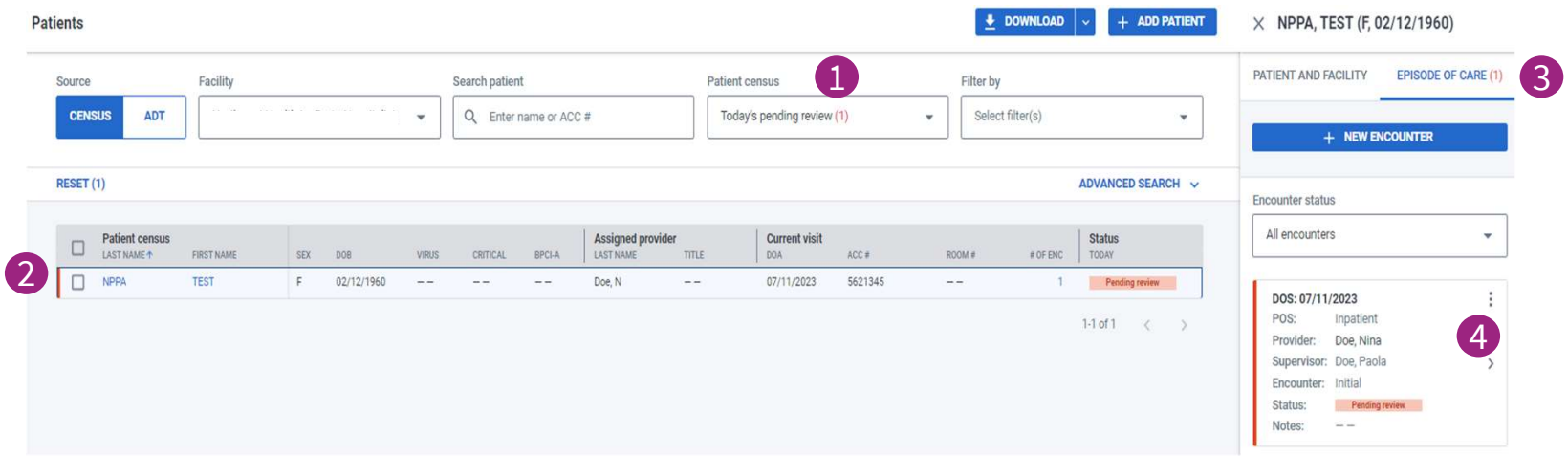
Demonstration

Reviewing NP/PA Shared Encounters in mySCP Care

SCP HEALTH

Documentation Tips for HM

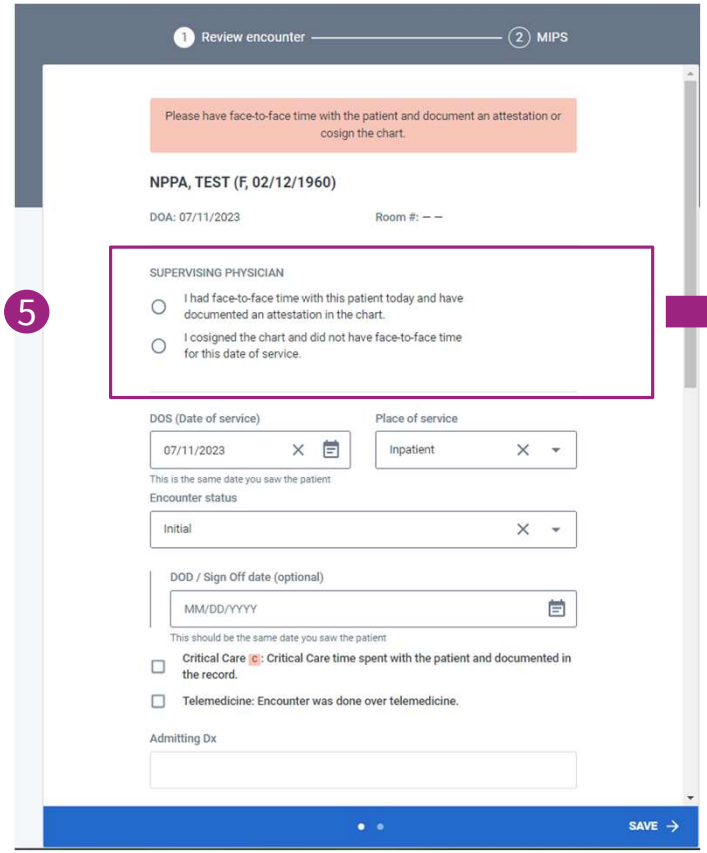
mySCP Care: How to Access Encounters Pending Review



1. Under Patient census select Today's pending review from the drop-down list
2. Select the patient
3. Once side pane opens, select Episode of Care
4. Select encounter that is pending review

Documentation Tips for HM

mySCP Care: How to Access Encounters Pending Review

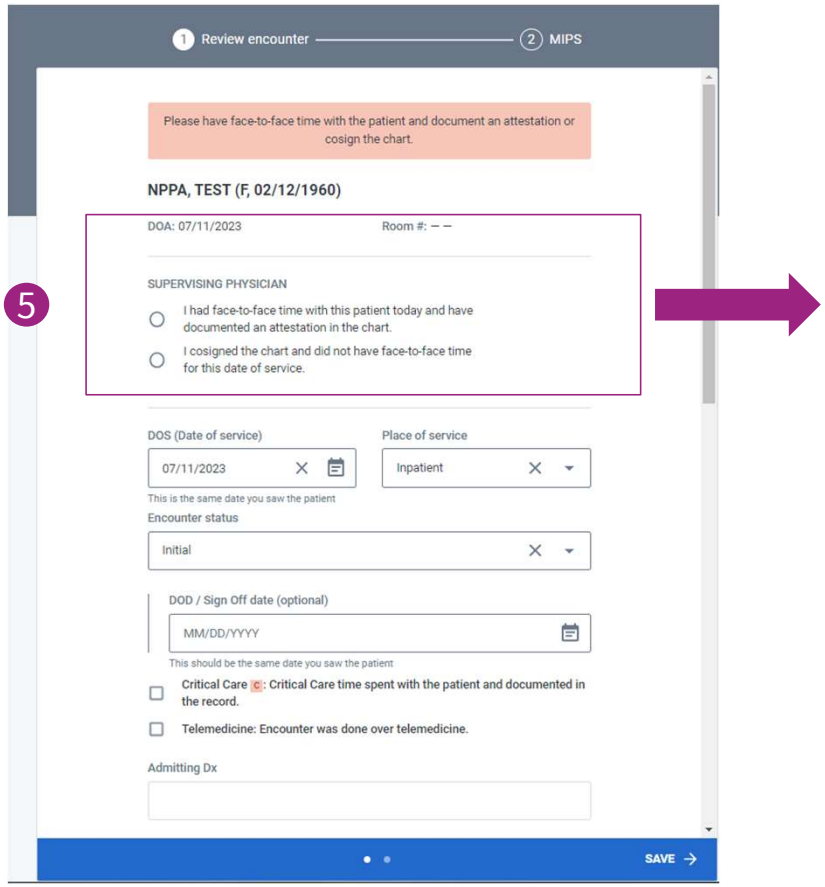


Identifying Co-signature vs. Face to Face

5. Under supervising physician, select the correct bullet:

- I had face to face time with this patient today and have documented an attestation in the chart.
- I cosigned the chart and did not have face-to-face time for this date of service

Identifying Co-signature vs. Face to Face



5. Under supervising physician, select the correct bullet:

- I had face to face time with this patient today and have documented an attestation in the chart.
- I cosigned the chart and did not have face-to-face time for this date of service

MIPS: Screening for Social Drivers in mySCP Care

SCP HEALTH

Documentation Tips for HM

MIPS #487: Screening for Social Drivers of Health

- Patients screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety.

✓ Ensures **health equity**, the highest level of health for all people regardless of race, ethnicity, disability, sexual orientation, gender identification, socioeconomic status, geography, or other factors that affect access to care and health outcomes.

- **Applies to:**
  - All patients **18 years of age** or older billed as **Inpatient** (Initial, Subsequent, and Consultation), **Rehab or Pysch** (Initial and Consultation), **Outpatient and Observation** (Consultations), and **SNF/NF** (Initial and Subsequent). **Telehealth** is allowed.

- **How to document:**
  On your H&Ps, Consult Notes, and Progress Notes add the following section:

Social Drivers of Health:

The patient was screened for social drivers of health including food insecurity, housing instability, transportation needs, utility difficulties and interpersonal safety.

Areas identified for concern are:

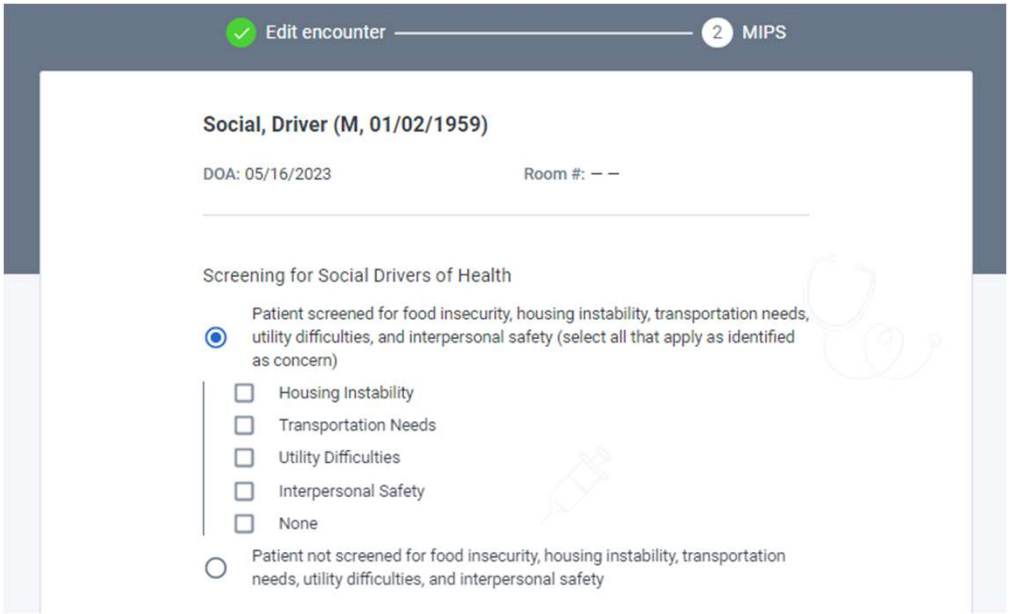
<list area/circumstance>

None

Documentation Tips for HM

MIPS #487: Screening for Social Drivers of Health

After entering your encounter in mySCP Care, you will be prompted in the MIPS section with the Screening for Social Drivers of Health question.

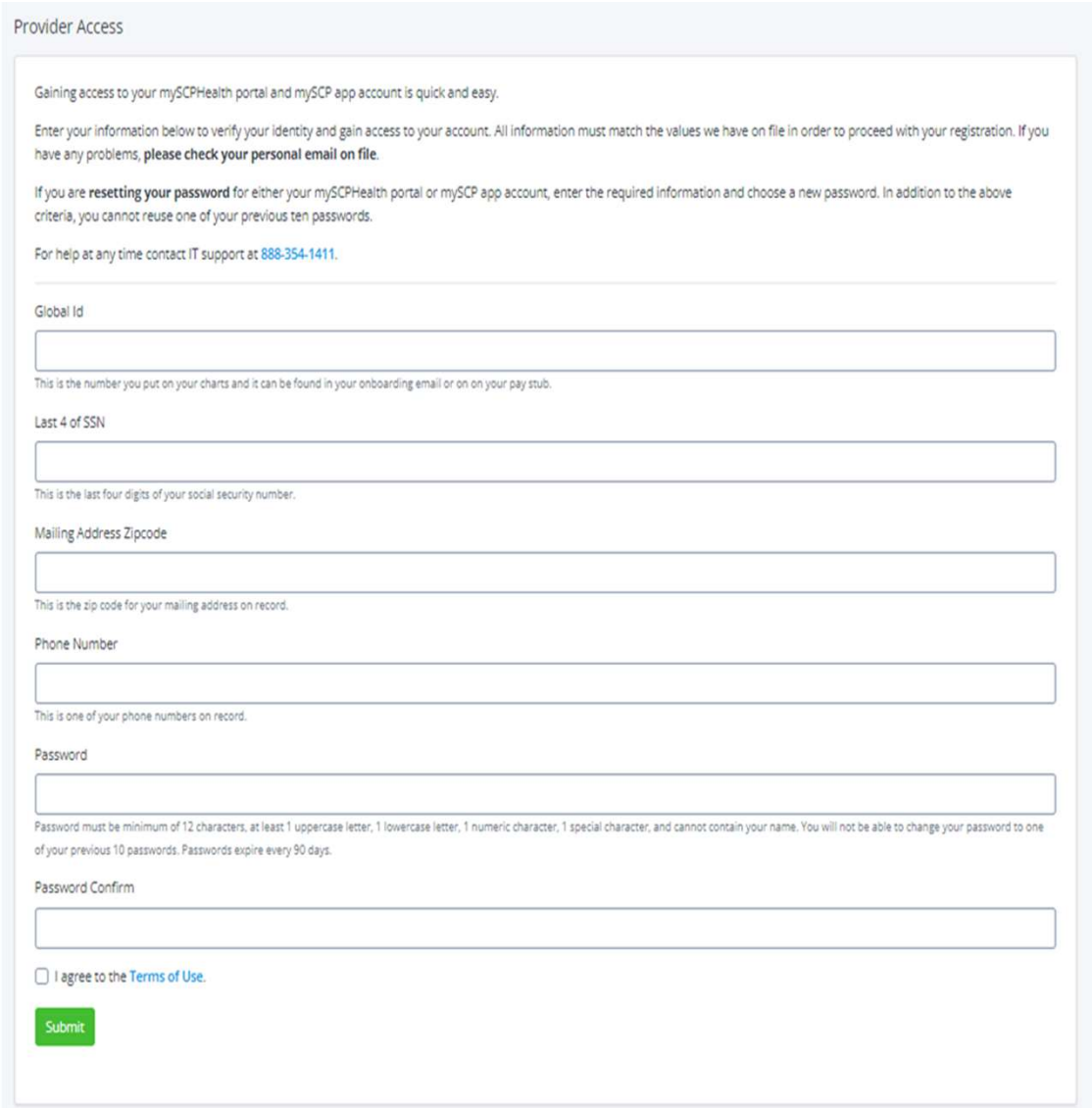


mySCP Care

Getting Started

Creating your SCP Account

1) Go to https://www.myscphealth.com/login-help/provider-access
2) Complete the information requested, including your Global ID, last 4 of SSN, Mailing Address Zip Code, and Phone Number on record and then create your own password.
    a. Your global ID was sent to you via email. You can also email your Documentation Specialist at hmdocumentation@scphealth.com to provide it.
3) Once your information is entered, select the box next to I agree to Terms of Use then select *Submit*.
4) This will launch you into the Provider Portal. Make note of your username (firstname.lastname) and the password you created.



mySCP Care

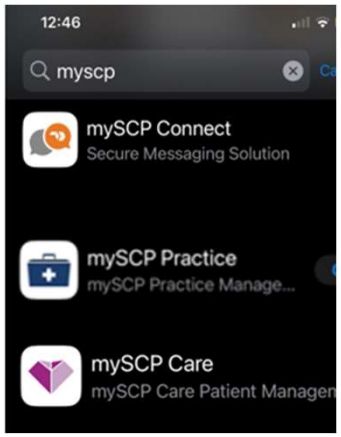
Mobile Version

Accessing mySCP Care

Mobile version: Download mySCP Care and mySCP Connect via the App Store or Google Play

1) To download, search mySCP in the App Store of Google Play. There will be 3 mySCP applications available: mySCP Care, mySCP Connect and mySCP Practice. **Download all 3.**

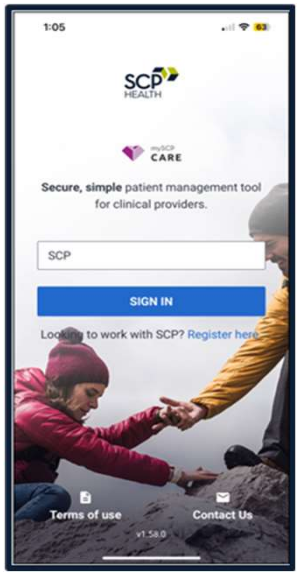
IOS view of App Store:

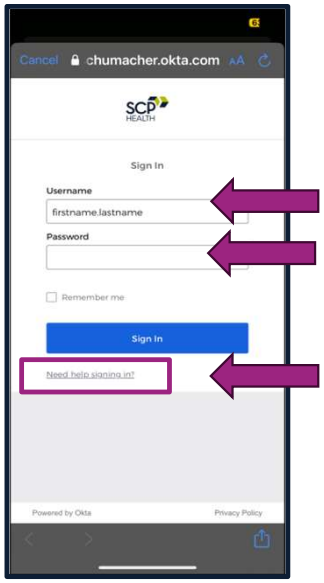


mySCP Care

Mobile Version

3. Enter your organization host name, then your username and password.
   *Will integrate with OKTA credentials and multifactorial authentication is required.
4. After initial log-in you may be given the option to add a passcode, face ID, or thumbprint ID for quick entry.
   *This is optional.





mySCP Care

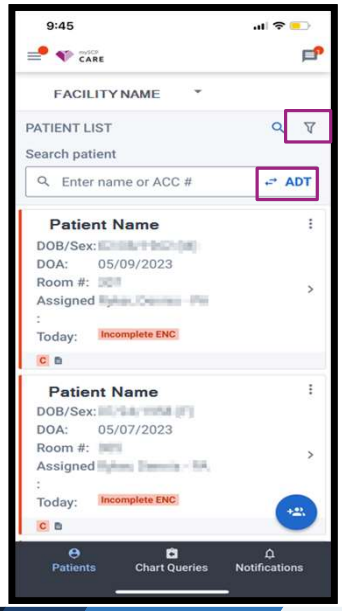
Mobile Version

Adding a Patient to the Census

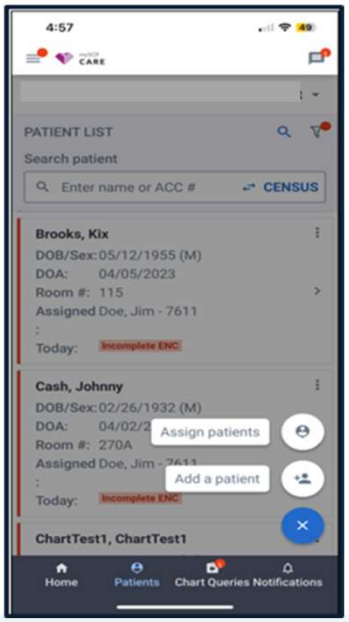
1. From ADT/Census: Select the magnifying glass and search the patient. Change your source by tapping “ADT” or “Census”. Select the patient and assign them to yourself.

ADT: for new admissions/transfers
not available at every facility

Census: existing patients



2. Manually Add: Select the blue circle icon then add a patient. On the next page, you need to input the patient’s last name and first name, DOB, Sex, then scroll down.

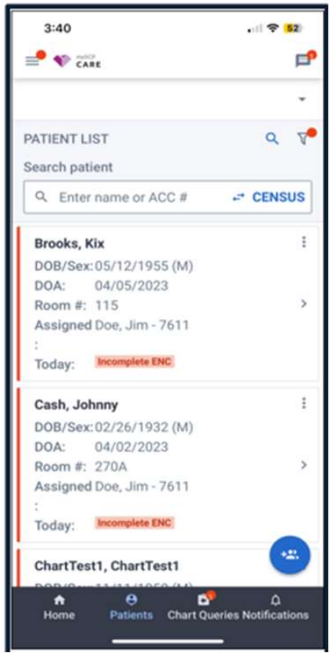


mySCP Care

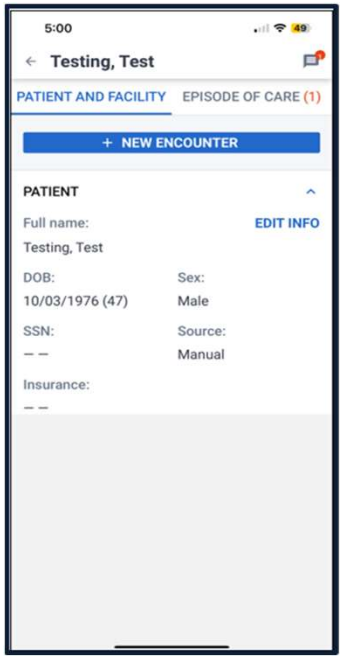
Mobile Version

Entering Encounter Details (Daily Visits)

1. Choose your patient from the census list



2. On the next page, you will select "+ New Encounter" to add the patient encounter performed for the DOS.



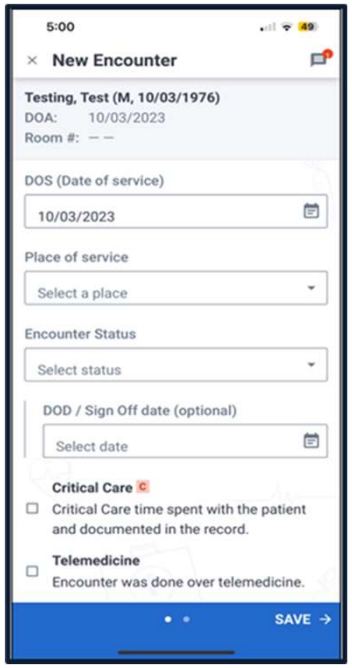
mySCP Care

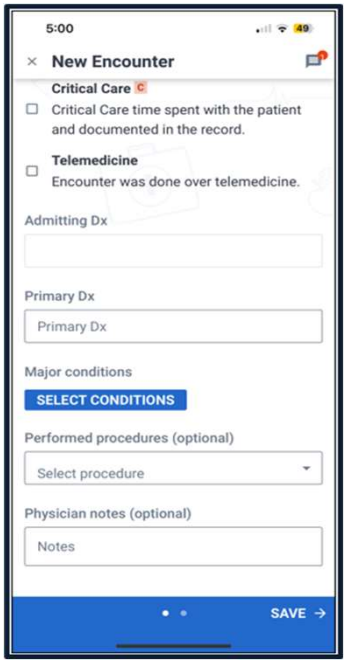
Mobile Version

Entering Encounter Details (Daily Visits)

3. Enter the DOS for the date you are seeing the patient. Input “Place of service” and “Encounter Status” (Initial, Subsequent, Discharge).

4. If you performed critical care greater than 30 minutes, click the Critical Care check box shown (you will still need to document your Critical Care time in the EMR). If the encounter was done via Telemedicine, click the Telemedicine check box. Next, input your “Primary Dx” for the day you are seeing the patient.





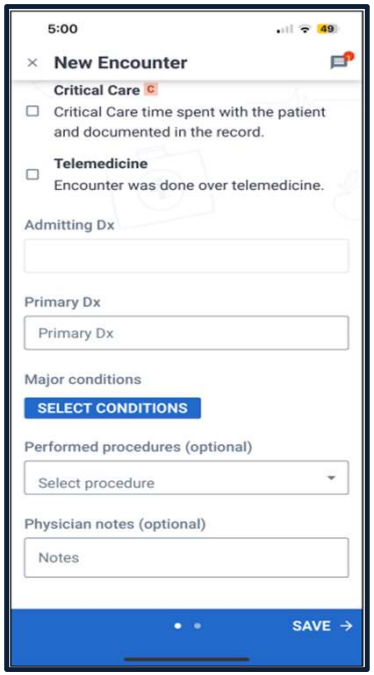
mySCP Care

Mobile Version

Entering Encounter Details (Daily Visits)

5. Select your “Major Conditions” and hit done.

6. Enter any “Performed Procedures” if performed. You can also add any “Physician notes” if you need to send one. Supervising physicians should only be chosen for those clinicians who are NP/PAs. Then hit “SAVE”.

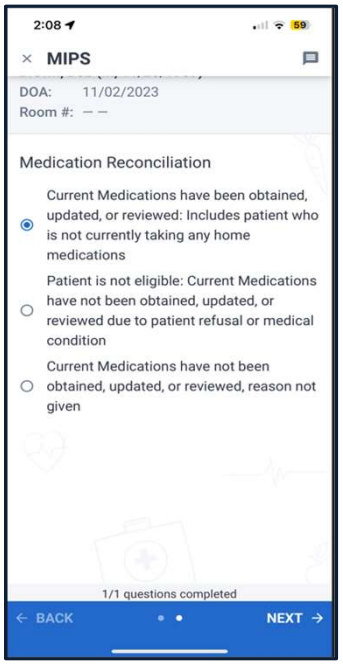


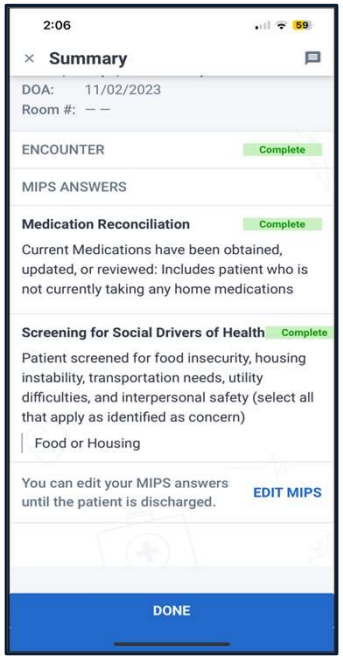
Documentation Tips for HM

mySCP Care Phone App

7. Once you have completed the prior screen you will be prompted to answer any MIPS that apply to this patient/encounter.

8. Review and answer the MIPS questions for all that appear. Click ‘Next’ until you have answered all questions. Then click “Done” once you have answered them. The MIPS titles do change to green “Complete” if you answered the questions.

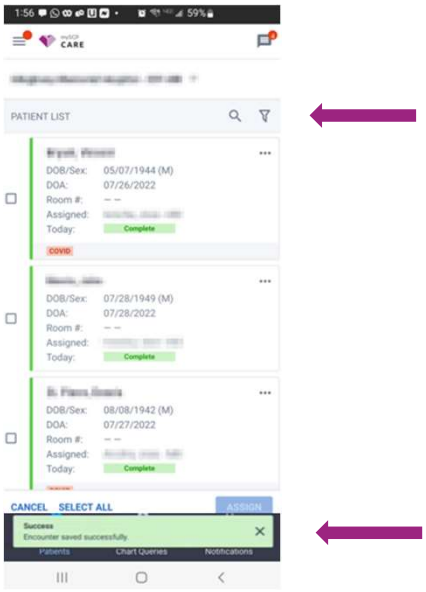




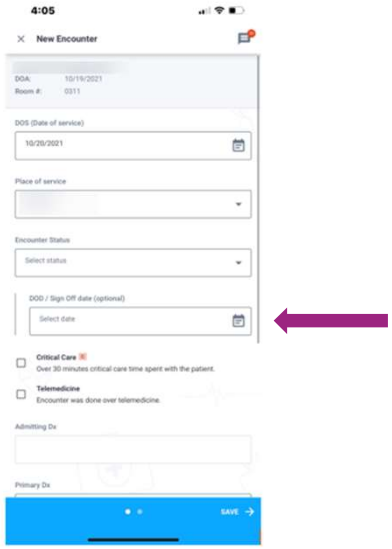
Documentation Tips for HM

mySCP Care Phone App

9. Once you have inputted the encounter for the patient then your screen should return to your “Patient List”. If you have entered the encounter correctly you should see at the bottom “Success, encounter saved successfully.”



10. Input the “Sign Off date” for the same “DOS” for encounter(s) that occur for consults, procedures, or additional critical care times.

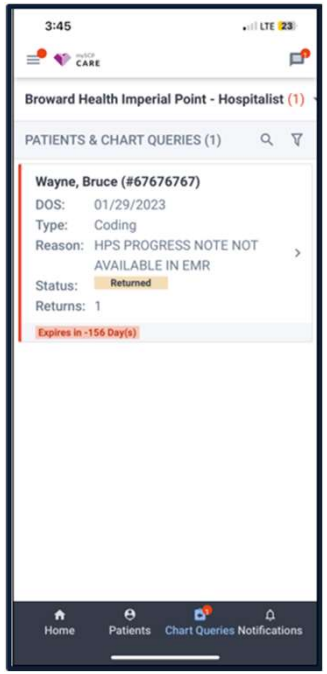


Documentation Tips for HM

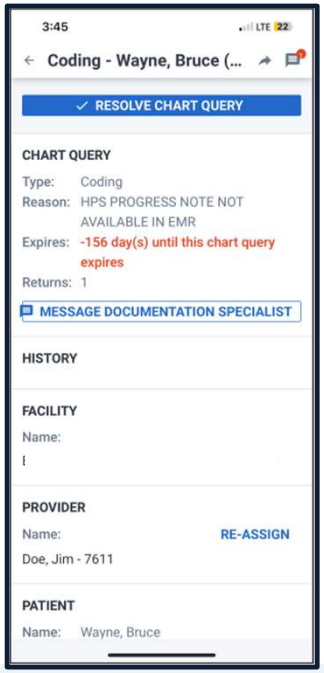
mySCP Care Phone App

Chart Queries: Select the Chart Queries tab from the bottom to view your list.

1. Select a patient from the list.



2. On the next page, you can select RESOLVE CHART QUERY, after updating your documentation in the EMR.

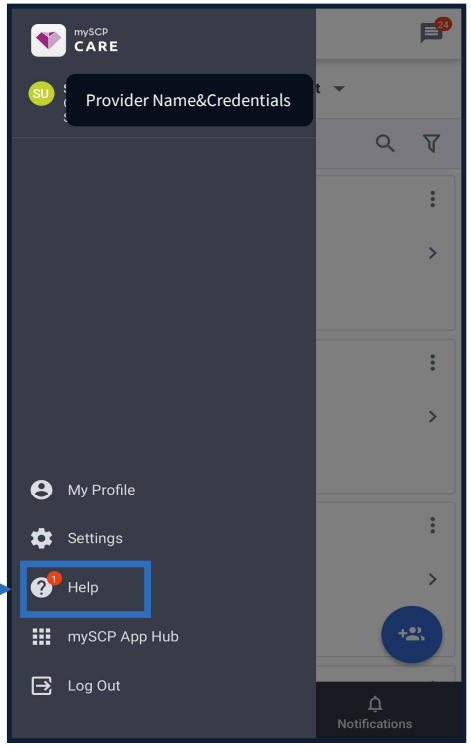


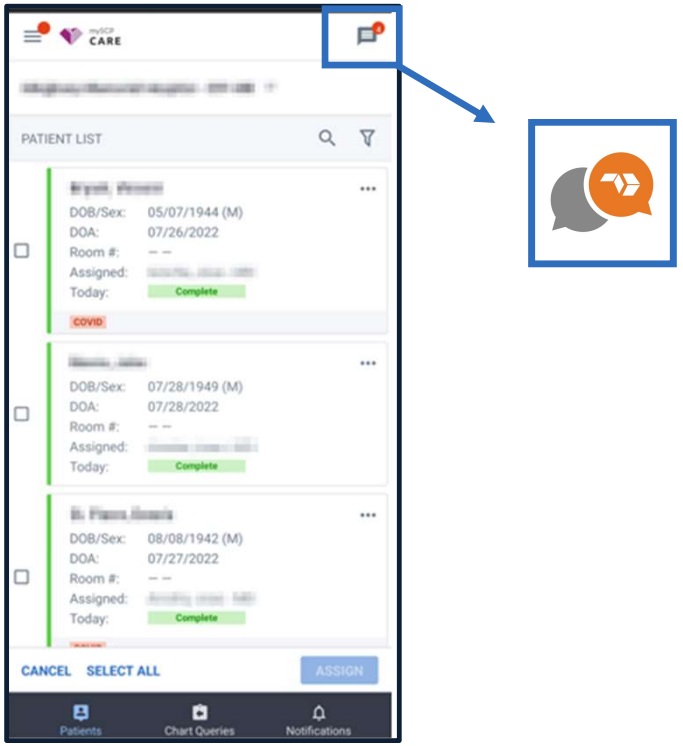
3. If you have questions about the query, DO NOT RESOLVE the query. Select “Message Documentation Specialist”

Documentation Tips for HM

mySCP Care Phone App

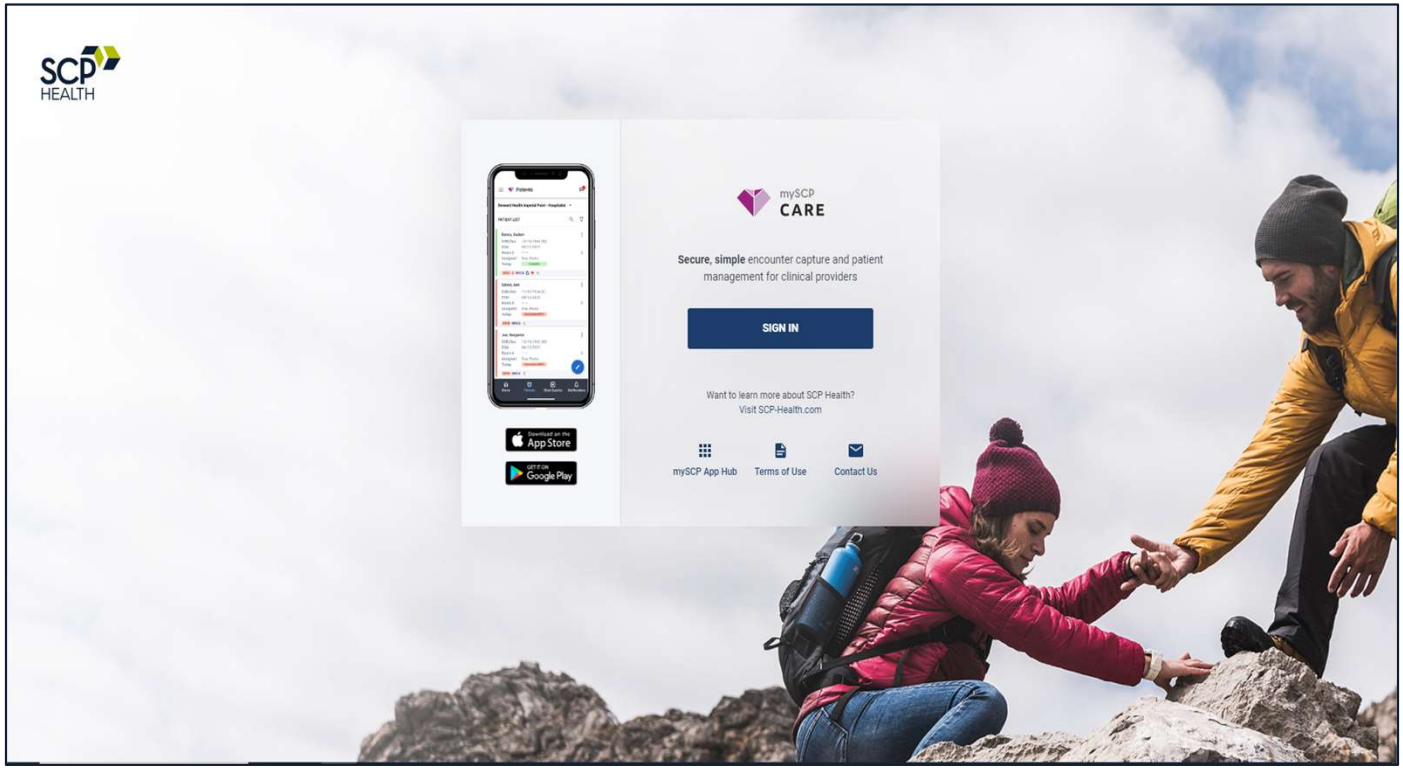
The help section of mySCP Care has 2–5 minute videos on use of the care app





Documentation Tips for HM

mySCP Care App Web Version



care.myscp.com

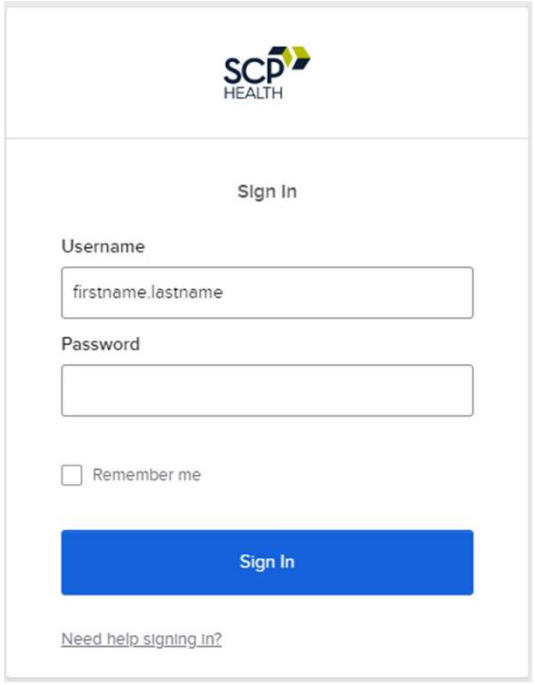
Reminder: please make sure your browser is updated to its latest version; we recommend Chrome.

Enter your organization host name (SCP) when prompted. (first time use only)

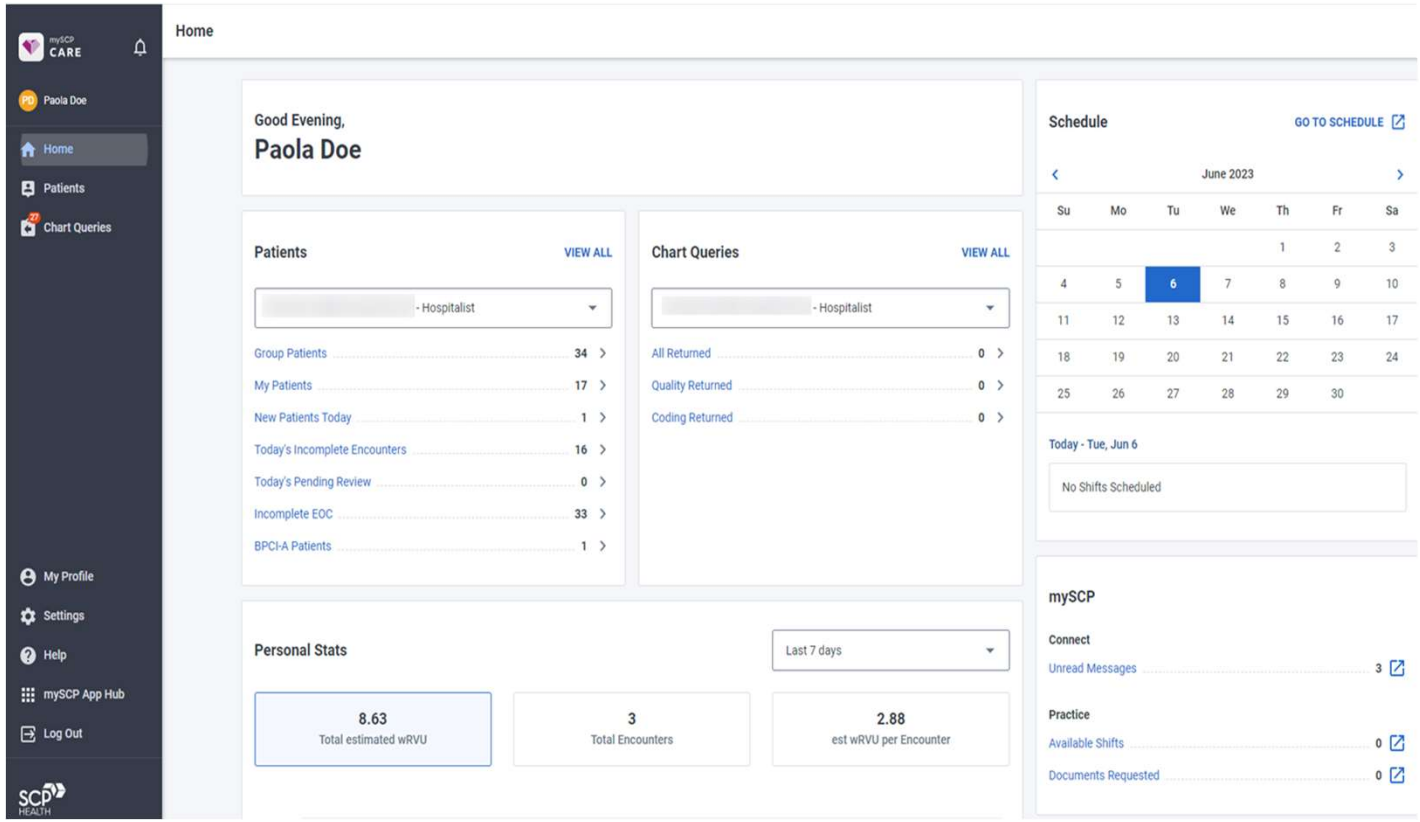
Documentation Tips for HM

mySCP Care App Web Version

Enter username, and password.



*Will integrate with OKTA credentials multifactorial authentication is required.



Documentation Tips for HM

For Assistance, Contact:

➢Email: **hmdocumentation@scphealth.com**

- This email is sent to team members within the Hospital Medicine Documentation Assurance Department
- A response should be received within 24 -72 hours

➢Main Line: (800) 893-9698

- Ask for Documentation Assurance

➢mySCP Connect or through mySCP Care application

➢References:

- ***AMA - CPT® Evaluation and Management (E/M) Code and Guideline Changes***
  - *https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf*
- ***CMS - Medicare Physician Fee Schedule Final Rule***
  - *https://www.govinfo.gov/content/pkg/FR-2022-11-18/pdf/2022-23873.pdf*
- ***ACEP - 2023 Emergency Department Evaluation and Management Guidelines FAQs***
  - *https://www.acep.org/administration/reimbursement/reimbursement-faqs/2023-ed-em-guidelines-faqs/*
- ***BSA Healthcare - 2023 Evaluation and Management Service Guidelines – Emergency Medicine Provider Documentation Training***
  - *www.bsahealthcare.com*
  - *Username: SCP2023 Password: Clinician2023!*

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Thank You for Attending!

Questions?