



SAINT LOUIS UNIVERSITY
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Attestation (Linking) Statements for E/M Services

By: Annetta Slover, Education Manager

While physicians have to master the rules on coding and documentation, supervising physicians have to oversee two different sets of documentation: their own, and the residents that they are supervising. According to Centers for Medicare Services (CMS) guidelines, the teaching physician must distinctly document the active role they play in the patient's evaluation and treatment. Just co-signing the residents' documentation is not enough.

Supervising physicians are responsible for ensuring that patients seen by residents receive the same standard of care as if they were working by themselves. In order to bill for a service as a supervising physician, you must personally perform key portions of the service or observe a resident performing those key components.

For purposes of payment, E/M services billed by teaching physicians require that they personally document at least the following:

- That they performed the service or were physically present during the key or critical portions of the service when performed by the resident; and
- The participation of the teaching physician in the management of the patient.

When assigning codes to services billed by teaching physicians, reviewers will combine the documentation of both the resident and the teaching physician. Documentation by the resident of the presence and participation of the teaching physician is not sufficient to establish the presence and participation of the teaching physician. On medical review, the combined entries into the medical record by the teaching physician and the resident constitute the documentation for the service and together must support the medical necessity of the service. (CMS Manual System; Pub 100-04 Medicare Claims Processing)

If a resident participates, the resident should be documenting the elements that they personally participated in.

An attestation statement, also known as linking or tethering statement, is necessary when a resident is present. Based on guidelines from CMS, here are some examples of acceptable attestation statements:

- "I performed a history and physical exam of the patient and discussed his management with the resident. I reviewed the resident's note and agree with the documented findings and plan of care."
- "I was present with the resident during the history and exam. I discussed the case with the resident and agree with the findings and plan as documented in the resident's note."
- "I saw and evaluated the patient. I reviewed the resident's note and agree, except that the teaching physician would insert their exceptions to the residents documentation at this time "
- "See resident's note for details. I saw and evaluated the patient and agree with the resident's finding and plans as written."

If the teaching physician personally performs all the required elements of an E/M service and performs all the documentation themselves, they would not add the attestation statement. In the absence of a note by a resident, the teaching physician must document as he/she would document an E/M service in a nonteaching setting.

Based on guidelines from CMS, here are some examples of unacceptable attestation statements:

- "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; and a legible countersignature or identity alone.

The statements above are insufficient because the documentation does not make it possible to determine that the teaching physician was present, that they evaluated the patient, their review of the findings, and/or their involvement with the plan of care for the patient.

<http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2303CP.pdf>



ICD-10 Still on the Horizon

By: Anne Schwartze, RHIA, CPC
Physician Billing Auditor

In April of 2014 the Protecting Access to Medicare Act was signed into law. Primarily this bill provided a temporary fix to the Sustainable Growth Rate that threatened to cripple Medicare reimbursement to physician's by 21%. However, seven lines in provision 212 were slid in almost silently that prevented the Department of Health and Human Services from implementing ICD-10 until *at least* October 1, 2015.

This year in late March, the US House of Representatives passed the Medicare Access and CHIP Reauthorization Act. This bill provides a permanent replacement to the Sustainable Growth Rate and does not include any language that would delay ICD-10 for a second time. The Senate will make their vote on the act when they come back into session in mid-April.

Despite everyone beginning to see light at the end of the tunnel, Tom Sullivan from HIMSS media (Healthcare Information and Management Systems Society) has stated, "It's simply unwise to think that ICD-10 proponents are insulated from another out-of-the-blue surprise," in his April 1, 2015 article "3 ways Congress could still kill ICD-10." However, according to the Centers of Medicare and Medicaid Services ICD-10 will still take effect on October 1, 2015.

SLUCare's Practice Management Operations department has implemented a training program for staff members to expand upon their ICD-10 knowledge. As of now, 73% of the staff required to participate have completed this training. To supplement the education on ICD-10, the Office of University Compliance plans to connect with SLUCare's individual departments for specialty-specific ICD-10 training in the future.

References:

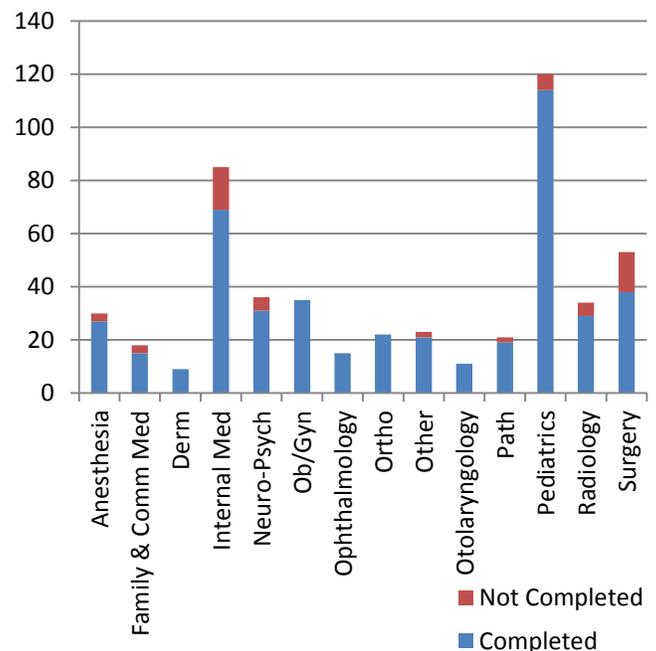
[3 ways Congress could still kill ICD-10](#)
[House Passes SGR Replacement Bill, ICD-10 Not Affected](#)
[President Signs SGR 'Patch' Bill, ICD-10 Officially Delayed](#)
[Centers for Medicaid and Medicare Services](#)

Department Assistance Appreciated in Physician Disclosure Process

89% of SLUCare's physicians have submitted their Physician Disclosure Statement in accordance with the University's Policy on Medical Center Conflicts of Interest in Patient Care & Service. The departments' administrative assistants have joined the effort to encourage **All Physicians** to complete a disclosure statement on their financial dealings with health care product companies during the 2014 Calendar Year.

All of the necessary information can be found at this site: <http://www.slu.edu/general-counsel-home/compliance/sunshine-act>. The physicians are encouraged to select the sun emblem "Click Here for the Disclosure Statement" and they will be prompted to answer a series of questions related to their relationships with industry. The feedback gathered from others is that it takes less than 10 minutes to complete.

The Compliance Office welcomes any question about the disclosure process; kborawsk@slu.edu, and thanks to all for working to satisfy this mandatory annual reporting requirement. Congratulations to the Departments of Dermatology, OBGYN, Ophthalmology, Orthopedics and Otolaryngology for 100% Completion!



Use of Patient Photos

Cameras seem to be everywhere, as you wait at traffic signal and look up you will see cameras on the traffic light and over on the corner lamp post. In today's world, cameras are not only packed and carried with you on a family vacation or at a special event, cameras are everywhere we go. Cameras can be found on the most basic flip phone to the latest high tech smartphone. These cameras are in our pockets, purses, and even in our hands while we walk. In the world of healthcare camera may be used but, only with the correct authorizations.

Since the HIPAA Privacy Rule went into effect in 2003, disclosures of protected health information (PHI) have required a patient's written authorization compliant with HIPAA regulations. Any photo that could individually identify a patient is considered to be PHI under HIPAA. Patient photos may be requested to be included in treatment documentation, educational materials, and even media publications.

Approved Camera Usage:

Only hospital or departmental designated cameras may be utilized for obtaining patient images. Use of these cameras must adhere to appropriate safeguards to assure patient confidentiality. Appropriate safeguarding of departmental cameras includes procedures to ensure that cameras are locked away in cabinets when not in use. Images should be downloaded from the camera to a secure location as soon as reasonably possible and then deleted from the device. Maintaining a user log of access will allow for monitoring when cameras were checked out and images were last removed from the camera. *Personal recording devices, including cell phones, iPads, and personal cameras, are not allowed for use in clinical treatment areas for capturing patient photos.*

Approved Photo Usage:

Patient images, videos, or audio recordings may be captured by a departmental designated camera when a valid HIPAA authorization has been obtained from the patient or the patient's legal authorized representative. The authorization must include the purpose (i.e. publication, external presentations, education and training of healthcare professionals) and describe what images will be used or disclosed. Residents involved in clinical care should expect that they may be taking images when seeing patients in the ER or on rounds with traumatic wounds and plan ahead for the use of designated departmental cameras.

Any patient photo that is individually identifiable is considered PHI under HIPAA and requires an Authorization for use or disclosure if it does not constitute treatment, payment or operations. The "**SLU Authorization to Use or Disclose Patient Image**" form should be utilized when a Patient Authorization is needed. If there is a possibility that identifiable photos may be used for presentations, publications, or reference material outside of Saint Louis University, they must be de-identified and reviewed before released. Identifiable images includes facial photos, tattoos, images that include medical record, patient name, case id, or any other unique identifying information.

Authorization Required:

- Publication, poster, website, or marketing materials
- Presentation used *outside of SLU*
- SLU presentation with *outside audience members*

Authorization NOT Required:

- SLU Teaching/Training Program
- Treatment Documentation
- General Purpose (images that are NOT identifiable)



When images are utilized for internal training or education purposes, the **Minimal Necessary Rule** should be followed and identifiable information removed or de-identified.

Please contact the Privacy Officer, Ron Rawson, 314-977-5884 or rawsonr@slu.edu, with any questions related to the Use of Patient Photos.

Who's in the Dog House?

In 2014 Johns Hopkins Hospital agreed to a \$190 million settlement (one of the largest of its kind) with more than 8,000 patients of a gynecologist who secretly photographed and videotaped women in the examining room. His conduct had been reported to the hospital by a female co-worker and he was fired. The files were found in his home after he committed suicide. Some of his patients filed a potential class action lawsuit.

In court papers, plaintiffs also contended that physician "engaged in doctor-patient boundary violations during the course of his patients' treatment," including "an excessive number of unnecessary pelvic exams and engaging in inappropriate physical contact." Some said he practiced without medical professionals on hand as observers, a routine hospital practice for the safety of patients and doctors. Johns Hopkins reported it had identified more than 12,500 potential victims.

Somewhat surprisingly, this incident does not seem to be recorded at all in HHS's public breach tool. It's therefore possible that OCR is still investigating this incident and that Johns Hopkins could be facing other consequences apart from the lawsuit.

