

Description:

One component of the PACE Medical Record Keeping Course (MRKC) is a customized chart review workshop. Your records will be reviewed by our compliance experts, who will compare them with your fees record (billing sheet), and critique the CPT codes and documentation to support the specific codes billed. A confidential report will be prepared for you, and a seminar regarding common documentation and coding errors will take place in a small group setting.

This workshop was created based on suggestions from previous course participants. We view this as an extremely valuable component of our course; we hope that the individualized feedback that it provides will enhance your learning experience.

Objective:

1. Review an individual participant’s actual medical records and associated encounter forms (e.g., billing forms, superbill, etc.) copy of CMS 1500 form for:
 - a. Medical content
 - b. Documentation format / completeness.
 - c. Legibility
 - d. Abbreviations
 - e. Coding accuracy (CPT, ICD9, modifiers)
2. Provide a customized, confidential summary of the submitted record(s) to each participant for purposes of education and medical record keeping improvement. All records will be returned to the participant.
3. Discuss common documentation and coding errors in a small group setting.

Instructions to Participants:

1. Select 1 typical medical entry (e.g., progress note, operative note, procedure note, dictated or handwritten) for 5 separate patients that you personally treated during the last two months. We suggest selecting a work day at random and using the first 5 encounters of that day. Please also include the encounter form/ superbill & CMS 1500 form. If you have a billing company that does your billing, ask them for a copy of the CMS 1500 form.
2. Photocopy the original progress note or procedure note and billing abstracts for the selected patient(s).
3. *Blind the photocopy* by using a heavy black marker to cross out any specific identifiable patient health information. Please make sure that the lettering is not legible through the marker. See page 3 for a list of data and information that is considered to be protected health information (PHI) under HIPAA Privacy Law.
4. For reference purposes, please number the upper right corner of each page of the set of records as follows: *your initials–Patient “A”–Page 1; your initials–Patient A–Page 2; your initials–Patient B–Page 1; etc.* (See Figure 1).
5. Send in one copy of each patient note, blinded, with identifying information, (such as Pt A pg. 1, Pt A pg. 2 etc.).
6. **Please adhere to the submission deadline indicated in your confirmation letter.** Mail the chart copies with a cover letter or a business card showing your return address to:



Fig. 1. Properly labeled, blinded chart.

Keir Kimbrough
Medical Record Keeping Course Administrator
UCSD PACE Program
1899 McKee Street, Suite 126
San Diego, CA 92110

PACE Medical Record Keeping Course
Chart Review Workshop: Individual, Personalized
Review of Medical Records

Late and/or Unacceptable Records:

The date by which you are required to submit your records is indicated in your confirmation letter. The PACE Program makes every effort to review all records, but cannot guarantee that late records can be processed. If your records are not received in time to be reviewed, you will not be able to complete all components of the course and thus will not receive credit. In that event, you will be able to attend the course, but will receive no certificate of completion.

Please note that the PACE Program *will not accept* original records, records that have not been blinded, or faxed copies of records.

Chart Review Workshop:

The workshop will be held in the evening of the first course day. You will receive your personal assessment at this time. The workshop is mandatory, and it is included in the \$1,300 course registration fee.

DISCLAIMER AND LIMITATION OF RESPONSIBILITY

Participant acknowledges that UCSD shall not be responsible for the consequences attributed to or related to any use of any information in the training sessions or seminar syllabus provided by UCSD. The training sessions and accompanying seminar syllabus are only advisory guidance on the use and interpretation of authoritative coding references. The syllabus is for use only as a supplement to the training sessions and in no way is a substitute for authoritative coding references. UCSD Health Sciences, its employees, agents and staff make no representation or guarantee that the use of this syllabus will prevent differences of opinion or disputes with Medicare or other third-party payers as to the amount that will be paid to providers of service.

Any five-digit numeric Physicians' Current Procedural Terminology, Fourth Edition (CPT) codes, service descriptions, instructions and/or guidelines are Copyright 2002 American Medical Association (or such dates of publication of CPT as defined in the federal copyright laws.) All rights reserved.

The training sessions include only CPT codes and descriptions selected by UCSD Health Sciences staff for inclusion in the workshop.

Protect your patient’s privacy—it’s the law!

Department of Health & Human Services
Health Insurance Portability & Accountability Act (HIPAA) Privacy & Security Laws
Excerpt regarding “Protected Health Information” or PHI:

Protected health information (PHI) means individually identifiable health information:

- (1) Except as provided in paragraph (2) of this definition, that is:
 - (i) Transmitted by electronic media;
 - (ii) Maintained in any medium described in the definition of electronic media at § 162.103 of this subchapter; or
 - (iii) Transmitted or maintained in any other form or medium.

- (2) Protected health information excludes individually identifiable health information in:
 - (i) Education records covered by the Family Educational Right and Privacy Act, as amended, 20 U.S.C. 1232g; and
 - (ii) Records described at 20 U.S.C. 1232g(a)(4)(B)(iv).

The following table lists details which must be blacked out from your charts:

<i>De-Identification of PHI: Data that relates identifiers of the individual or relatives, employers, or household members of the individual: [#164.514, p. 82818]</i>	
1	Names
2	All geographic subdivisions smaller than a state (except for initial 3 digits of a zip code if the public census is more than 20,000 people)
3	Dates (all elements of dates directly related to the individual, including birth date, admission date, discharge date, date of death; and all ages over 89 and all elements of dates)
4	Telephone numbers
5	Fax numbers
6	Electronic mail addresses
7	Social security numbers
8	Medical record numbers
9	Health plan beneficiary numbers
10	Account numbers
11	Certificate / license numbers
12	Vehicle identifiers and serial numbers, including license plate numbers
13	Device identifiers and serial numbers
14	Web Universal Resource Locators (URLs)
15	Internet Protocol (IP) address numbers
16	Biometric identifiers, including finger and voice prints
17	Full face photographic images and any comparable images
18	Any other unique identifying number, characteristic, or code
19	ii. The covered entity does not have actual knowledge that the information could be used alone or in combination to identify an individual who is a subject of the information.