EMR Issues with Documentation, Coding and Audits

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EHR: The Hope

- Access to timely, accurate, detailed patient information
- Point-of-care clinical decision support
- Patient-centric care delivery methods
- Data analysis opportunities
  - Individual patient
  - Population studies

Benefits of EHR

- Data is generally readable
- Quantity of documentation increases, so too little information is less frequent
  - Good for supporting coding
  - Good for medico-legal reasons
- Altering the medical record is more difficult
- Chart records are easier to find; fewer missing

AMA Survey

- 34% satisfied or very satisfied with their EHR systems, compared with 61% asked five years ago
- 42% of respondents described their EHR system’s ability to improve efficiency as difficult or very difficult
- 43% of respondents still addressing productivity challenges
- 54% of respondents said EHR system increased total operating costs
- 72% of respondents described their EHR system’s ability to decrease workload as difficult or very difficult

Survey Variables

- Size of practice
  - Physicians in large-groups having better EHR experiences
  - Large practices have more staff to support EHR adoption and maximization
  - Smaller practices bought inexpensive and / or free EHRs with little or no support.
- Server vs. Cloud-based
  - Improvements in web-based EHRs have “reversed overall satisfaction . . .”
- Time
  - 3 years of use or less – 25% satisfied
  - 5 years or more – 50% satisfied

Source: https://www.advisory.com/_apps/dailybriefingprint?i={DA4C756B-2473-4F9F-B7CA-F689A59A33C} – Published August 2015

EHR Documentation Issues

“Garbage in . . . Garbage out”

EHR Integrity Issues

- Confusion from nonsensical language
- Difficulty identifying relevant information
- Copying prior records that contain errors
- HIPAA violation when information copied from one patient record to another
- Patient care issues arising from inaccurate records
- Possible malpractice concerns

Target for Scrutiny

E/M: Potentially Inappropriate Payments

“We will determine the extent to which CMS made potentially inappropriate payments for E/M services in 2010 and the consistency of E/M medical review determinations. We will also review multiple E/M services for the same providers and beneficiaries to identify electronic health records (EHR) documentation practices associated with potentially improper payments. Medicare contractors have noted an increased frequency of medical records with identical documentation across services. Medicare requires providers to select the code for the service on the basis of the content of the service and have documentation to support the level of service reported.”

Source: HHS OIG Work Plan

Reimbursement

- OIG to CMS: Make EHR fraud prevention efforts a priority
- OIG said, the CMS neglected to provide adequate guidance to its contractors tasked with identifying said EHR fraud, citing the fact that the majority of these contractors reviewed paper records in the same manner they reviewed EHRs, disregarding the differences. Moreover, only three out of 18 Medicare contractors were found to have used EHR audit data in their review process.


“Cloning”

CLONED DOCUMENTATION COULD RESULT IN MEDICARE DENIALS FOR PAYMENT

Documentation is considered cloned when it is worded exactly like or similar to previous entries. It can also occur when the documentation is exactly the same from patient to patient. Individualized patient notes for each patient encounter are required. Documentation must reflect the patient condition necessitating treatment, the treatment rendered and if applicable the overall progress of the patient to demonstrate medical necessity


Common Issues with Copy-Paste

- Boilerplate records that overlap, either page after page, over time or from one patient to another. For instance, a patient’s blood pressure should not be identical at every visit.
- Gender confusion in records. For example, at a practice that treats men and women, every patient is referred to as “he” in chart notes because the doctor copied a part of a note from one record and used it as a template in all of his notes.

Source: Part B News 10/3/16
Common Issues with Copy-Paste

- Repeated typographical and spacing errors. That can indicate copying and pasting.
- Inconsistencies in the record, such as complaint of stomach ache with a detailed examination of the upper extremities.
- Overall higher reimbursement with electronic records when compared with paper records.

Living with Copy-Paste

- Minimize use
- Employ alternative approaches
  - Drop down menus
  - Pick lists
- Edit copied notations with new information
- Verify every copied notation and "click it"
- Have a written policy, stick to it and ENFORCE IT!

Charting Requirements

- What – detailed description
  - History
  - Examination
  - Other tests
- Why – evidence of medical necessity
  - Chief complaint, symptoms
  - History of disease
  - Related to severity of disease
  - Consider treatment options

Problematic Chief Complaints

EHR Examples

- “68 yo female presents for evaluation of Complete Exam in the right eye and left eye. The symptom is constant. It occurs all the time. Pt has no complaints.”
- “67 year old female complains of left eye in left eye for months.”
- “Decreased vision in both ears”
- “Borderline diabetes, it affects vision, not affected”
- “Cataract evaluation” (patient already had cataract surgery OU)

Efficiency – History Taking

"The extent of history of present illness, review of systems and past, family and/or social history that is obtained and documented is dependent upon clinical judgement and the nature of the presenting problem(s)."

Source: 1997 Evaluation and Management Guidelines

ROS and PFSH

Medical Necessity

- The ROS isn’t required on every visit
- The PFSH is not required on every visit
- Repeat the elements pertinent for the condition
Problematic Exam Documentation Examples

- CVF – fixes and follows OU – patient is monocular
- Lens – “clear OD” – patient is scheduled for cataract surgery OD
- External / lids – “WNL OS” – Procedure note for epilation of lashes LLL
- SLE – blank – impression indicates corneal ulcer OD
- VA = 20/20 OS – Patient had enucleation OS 3 mos. prior

Accuracy – Plan

- Does it correlate to the chief complaint and impression?
- Is the discussion noted “canned” and used over and over?
- Is the discussion credible?

Accuracy – Diagnosis Codes

- Make primary diagnosis agree with the CC
- Record relevant systemic illness (e.g., DM)
- Watch for “carrying forward” diagnoses into impression that are historical
- Do not use diagnoses that no longer apply
- Limit use of “unspecified” ICD-10 codes

Documentation About Scribes

- EMR/Dictated Note:
  - Identification of scribe:
    - ‘Dictated by ______’
  - Notation from physician/NPP that he/she reviewed for accuracy:
    - ‘I agree with the above documentation’ or ‘I agree the documentation is accurate and complete’

Electronic Signature Policy

- Component of recent record requests from Strategic Health
- No single overwhelmingly accepted standard, law, or regulation on their use
- Policy outlines electronic signature process
- Example policy: http://library.ahima.org/PdfView?oid=107152

Code Inflation

- EHR users increase utilization of 99214, 99215
- RAC audits of these codes based on HHS OIG report – Coding Trends of Medicare Evaluation and Management Services, May 2012
- OIG states: “Although many EHR systems can assist physicians in assigning codes for E/M services, we found that most Medicare physicians manually assigned E/M codes.”
Charting Requirements

- For many EHR systems, office visit notations contain the same history and exam elements in all cases
- The only basis for stratifying the level of service is medical decision making
- E/M coding is moving toward applying new patient criteria on a universal basis

Medical Decision Making

“Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed.”

Established Patient Office Visits

2 of 3 Key Components

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Key Questions About HIM

- How long can a medical record remain open (incomplete) and unsigned?
- What reason(s) justifies keeping a record open?
- How is a closed record changed?
- What are your Health Information Management (HIM) policies?
- Does management track changes?

Best Practices

Editing / Amending

- Discuss with EHR vendor process of editing and amending
- Develop policies and procedures on how to edit and amend a patient encounter

Source: Medicare Internet Only Manual pub. 100-4, chapter 12
**Paper Records**
- Use a single-line strike-through of the original documentation
- Date it
- Sign it

**Addendums**
- Addendum – new documentation used to add information to an original entry (e.g., late info)
- Separate notation from the original
- Includes reason for adding information
- Current date
- Signed by provider
- If applicable, forward to other care givers who received the original note
- Recommended approach

**Amendments**
- Amendment – a note meant to clarify information within a health record
- Standout notation within the record
- Current date
- A second signature
- Authority to “unlock” a record must be restricted
- Use caution

**Audit Trail**
- EHR embeds a computer data trail for each key stroke
  - What was entered?
  - Who did it?
  - When?
- Management should make use of this feature during audits and education of physicians and staff

**Risk Management**
“EHRs have successfully addressed the handwriting issues and have been credited with preventing some types of harm such as medication errors. Nonetheless, EHRs have also created unintended consequences, including new sources of error and harm.”

**Risk Management – Case Study**
- Child diagnosed in ER with traumatic hyphema; exam noted dilated, non-reactive pupil
- On-call ophthalmologist EHR note indicates round, reactive pupil w/out APD
- Patient experiences loss of vision, sees 2nd ophthalmologist who notes vision NLP, pupil fixed and dilated, IOP 46
- Child ends up with HM vision, parents sue

*Source: OMIC Digest; Anne Menke, RN, PhD, OMIC Risk Manager, 2014*
Risk Management – Case Study cont. 
• First ophthalmologist reviews his note and realizes EHR populated normal findings, intended to change later, never did. 
• No IOP noted; physician recalls checking IOP 
• OMIC settled case with permission of MD for $380,000 

Source: OMIC Digest; Anne Menke, RN, PhD, OMIC Risk Manager; 2014

Risk Management – Case Study
• Plaintiff alleged delay in diagnosis of RD 
• EHR notes for several visits revealed exam findings contradicting physician’s assessment 
• Discrepancy caused by “carry forward” 
• Medical record issues convinced ophthalmologist to settle case for $290,000 

Source: OMIC Digest; Anne Menke, RN, PhD, OMIC Risk Manager; 2014

Reduce EHR Errors and Liability
• Train clinicians to use EHR appropriately 
• Include EHR documentation in compliance plan 
• Verify use of correct patient record 
• Develop consistent process for releasing information 
• Be alert to record release requests 
• Review information before releasing it 
• Report EHR’s role in potential malpractice claims 
• Use satisfaction surveys to catch errors 

Source: Decision Health / Medical Practice Compliance Alert 6/22/15

HIPAA
• Have a designated HIPAA-assigned compliance officer or team member. 
• Ensure access to ePHI is restricted based on job roles and / or responsibilities. 
• Conduct an annual HIPAA security risk analysis 
• Mitigate and address any risks identified during your HIPAA risk analysis. 
• Make sure policies and procedures match the HIPAA requirements. 

http://www.healthcareitnews.com/blog/don%E2%80%99t-confuse-ehr-hipaa-compliance-total-hipaa-compliance

HIPAA
• Require user authentication, such as passwords or PIN numbers 
• Encrypt patient information 
• Incorporate audit trails 
• Implement workstation security 

http://www.healthcareitnews.com/blog/don%E2%80%99t-confuse-ehr-hipaa-compliance-total-hipaa-compliance

Security Threats
• Threat – the potential for a person or thing to exercise (accidentally trigger or intentionally exploit) a specific vulnerability 
  • Natural threats 
  • Human threats 
  • Environmental threats

http://www.healthcareitnews.com/blog/don%E2%80%99t-confuse-ehr-hipaa-compliance-total-hipaa-compliance
Making a Change

“. . . 48% of small practices that switched EHRs between June 2014 and May 2015 report that the financial burden has put the practice in an unstable financial position.”


Making a Change – Why

• Does not meet practice’s needs
• Practice did not adequately assess needs before selecting original EHR
• EHR design not suited for the practice specialty or specialties
• Vendor not responsive to requests and needs

Source: http://www.hitechanswers.net/three-factors-in-switching-ehrs/

Making a Change – Considerations

• Clinical data from the legacy EHR will either need to be migrated to the new EHR or stored in an archive solution.
• Easy access to legacy patient information after you switch EHRs.
• Plan and coordinate the data conversion well in advance of the switch

Source: http://www.hitechanswers.net/three-factors-in-switching-ehrs/

Action Items

• Ensure only accurate and patient-specific entries are made in the EHR – avoid copy-paste
• Make only necessary entries – avoid filling cells just because they are empty
• Use medical decision making as the key factor for selecting the level of service of an E/M code
• Implement strong security measures to control risk of accidental release of protected health information
• Create an HIM policy for error correction – avoid reopening closed records

Source: http://www.hitechanswers.net/three-factors-in-switching-ehrs/

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