HCCA
hcca-info.org

Compliance TODAY

A PUBLICATION OF THE HEALTH CARE COMPLIANCE ASSOCIATION

AUGUST 2018

Building a consistent approach across broad enterprises

an interview with
R. Brett Short

by Ida L. Landry

Documentation compliance through knowledgeable staff and policy

» Have an EMR trainer and a coder or CDI person work in tandem with the provider and ancillary staff.

» CMS states that "features like auto-fill and auto-prompts can facilitate and improve provider documentation, but they can also be misused."

» When is cloning, copy-and-paste, cut-and-paste, pull forward, or carried forward information appropriate, if ever?

» "Per the metadata, it is not a systems error." Providers are responsible for recording patient encounters.

» No proof of specific intent to defraud is needed to commit a coding infraction.

Ida L. Landry *(ida.landry@cerner.com) is Corporate Compliance Manager, Professional Services at Cerner Corporation in Portland, OR.*

bit.ly/in-IdaLandry

Have you read the news about the $1 billion lawsuit against eClinicalWorks? The lawsuit stemmed from the patient not being able to determine within his medical records when his cancer first appeared. The plaintiff stated that eClinicalWorks is at fault, because their electronic medical record (EMR) had not saved the updated data entered.[1] Although this case was terminated February 13, 2018,[2] what alarmed me was that I have seen charts very similar to this patient's in EMR systems that are working correctly.

Landry

The fault in the defective documentation cannot be placed on the EMR system, but on that of the documenter. For example, I was talking with a friend a while back who was telling me about a state audit that she was overseeing as a liaison for the company she works for. The state auditor had printed out a provider's patient encounters. The encounters all read the same—word for word for every visit. The auditor asked my friend if what she was seeing with the notes was a systems error or a provider error. My friend replied, "Per the metadata, it is not a systems error." My friend could not tell me the result of that audit, but we both agreed that a lawsuit against a health system and a specific provider can easily happen because of current documentation trends. Honestly, if a lawsuit like this isn't in the works, it will be in the future. Health systems can make a few very easy changes to help minimize their risks.

Provider EMR training

Many health systems have teams of people who are experts in their EMRs. Trainers and super-users exist to help guide the providers and ancillary staff in their documentation. These individuals often are professionally trained by the EHR company and hold a certification. They know the tricks of the system and are happy to share the shortcuts to help minimize the time spent charting.

Although highly educated on the system, the trainers and super-users often lack education in medical coding and documentation requirements. "I was trained to document this way," "This is how I was trained," and "I was told it was okay to document this way" are all comments heard by coders or auditors when querying providers about their documentation. Excessive cloning, cut-and-paste, copy-and-paste, carried forward, and overusing templates can be the result of trainers who educate the providers on handy shortcuts.

A couple of solutions exist that can easily be implemented to help minimize the documentation risks. The first solution is to have an EMR trainer and a coder or clinical documentation integrity (CDI) person work in tandem with the provider and ancillary staff. As the EMR trainer goes through the documentation components within the EMR, the coder/CDI individual can provide the education on the documentation guidelines. For example, instead of the Review of Systems (ROS) and the Past Family Social History (PFSH) being pulled forward from another encounter note, the coder/CDI staff can provide the option of "noting the date and location of the earlier ROS and/or PFSH."[3,4] The coder/CDI person can follow up this guidance with a helpful reminder that the information from previous encounters must pertain to the current chief complaint to be useful when assigning a level of service for billing purposes.

information from previous encounters must pertain to the current chief complaint to be useful when assigning a level of service for billing purposes.

Another solution is to have all the EMR trainers and super-users go through training to understand the 1995 and 1997 Evaluation and Management Documentation Guidelines. Knowing what's in the guidelines and understanding that the information must be relative to the current encounter visit may help to decrease reliance on easy-to-use options and templates. Instead, the education would be focused on when using those options would be realistic.

Create policy

In 2013, the Office of Inspector General (OIG) proposed to the Centers for Medicare & Medicaid Services (CMS) that they develop guidance regarding copy-and-paste EMR features. Although CMS has commented on cloning, or copy-and-paste within their Electronic Health Records Provider Fact Sheet,[5] the information does little to educate and guide the medical community on their definitive definition of cloning. Instead, it references the OIG findings and cautions that the documentation needs to show "the differences and the needs of the patient for each visit or encounter." With this broad guidance to govern the compliance of documented medical goods and services, organizations are tasked to create their own guidance. This can be done by creating or updating a corporate and/or departmental policy.

Some may question why a policy should be written. We only have to look at the $422,741.50 fine that Somerset Cardiology Group, PC paid for allegedly violating the Civil Monetary Penalties Law.[6] This fine was based on Somerset's self-disclosure that

they up-coded services. It was not stated in the OIG notification if a policy played a part in the self-disclosure. What is noteworthy is that the "OIG contended that Somerset cloned patient progress notes…and higher level of service resulted in higher payments by Medicare." The penalty they paid is an indication that the OIG agreed with the self-disclosure and found credible examples of documentation issues to substantiate their claim.

Something else to consider, when thinking about creating or updating your documentation policy, is the provider action needed statement within CMS's Medicare Learning Network (MLN) Matters Related Change Request (CR) #: 3274, which states:

> Providers need to be aware that the acceptance of a voluntary refund as repayment for the claims specified in no way affects or limits the rights of the Federal Government, or any of its agencies or agents, to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims.[7]

Although implemented and first effective back in October 1, 2004, its relevancy is current today. This can be seen in Noridian's Jurisdiction F January 2018 Medicare B News paraphrasing the above statement and emphasizing its importance to providers.

Then we have the Affordable Care Act's (ACA) 60-day overpayment provision. Within its instruction it defines the words "knowing" and "knowingly" with regards to the truth or falsity of information. It goes on to state that there does not need to be proof of specific intent to defraud.

The amount of thought that has been put forth to combat overpayments, fraud, waste, and abuse is well stated. What is limited are the parameters of what defines the insufficiencies in documentation in relation to the evaluation and management coding. This is where creating a policy will help your organization if you are ever audited. When creating your policy, it would be helpful at a minimum to include:

1. The 1995 and 1997 Evaluation and Management (E/M) Documentation Guidelines.
2. Your local Medicare Administrator Contractor (MAC) interpretation of the guidelines.
3. Any other guideline, Act, or rule that you think would be beneficial to note within the policy.
4. Someone who has worked extensively with the E/M guidelines in relation to the MAC's interpretation.
5. A provider who has some understanding of the E/M guidelines and the EMR your organization uses.
6. Your compliance officer.
7. A chief medical officer.
8. Inside and/or outside counsel.
9. Anyone else whose expertise you value.

Be prepared to debate the documentation elements. There may be differences of opinions. When is cloning, cut-and-paste, copy-and-paste, or carry forward acceptable? CMS states that "features like auto-fill and auto-prompts can facilitate and improve provider documentation, but they can also be misused."[8] When does your organization determine that misuse has occurred? What does appropriate use of auto-fill and auto-prompt look like? When would your organization find templates to be appropriate? When is cloned, copy-and-pasted, cut-and-pasted, pulled forward, or carried forward information appropriate, if ever?

Once you have determined and defined what appropriate E/M documentation

elements looks like, you have a standard that the providers and ancillary staff can follow and the auditors can use as a guide. The organization is prepared for those times when an outside auditor or entity may question the documentation of a provider. Lastly, for those times when self-disclosure is necessary, you have something that will help to validate your organization's seriousness about document compliance.

Conclusion

The topic of documentation appropriateness is being discussed in the healthcare community with increased frequency. Tools, such as the Yates Memo, are helping the Department of Justice (DOJ) find fault in documentation users and coding infractions with more frequency. Fortifying your organization with educated individuals who can effective train on the EMR system, and giving documentation guidance will help combat poor documentation. Partnering this with a clear and concise documentation policy only adds to the compliance stability of the organization. With one gray area defined and appropriate training established, your Compliance department can focus on outliers and other healthcare compliance deficiencies.

1. Jessica Davis: "eClinicalWorks sued for nearly $1 billion for inaccurate medical records" *Healthcare IT News*; November 17, 2017. Available at http://bit.ly/2KubvM0
2. Bernie Monegain: "eClinicalWorks DOJ settlement one year later" *Healthcare IT News*; May 4, 2018. Available at http://bit.ly/2MuwcIt
3. CMS: 1995 Documentation Guidelines for Evaluation and Management. Available at https://go.cms.gov/2lD0nBJ
4. CMS: 1997 Documentation Guidelines for Evaluation and Management. Available at https://go.cms.gov/2MpdLF9
5. CMS: Electronic Health Records Provider Fact Sheet December 2015. Available at https://go.cms.gov/2yPRPB4
6. *Report on Medicare Compliance*: "Cloning of Progress Notes, Upcoding Lead to Fraud Settlement; Doctors Pay $422,000" (Somerset Cardiology Group, PC). *RMC* 2016;25(7). Available at http://bit.ly/2N5jAsj
7. CMS: Medicare Learning Network (MLN) Matters Related Change Request (CR) #: 3274: Unsolicited/Voluntary Refunds. July 30, 2004. Available at https://go.cms.gov/2N4UhXu
8. Ibid, Ref #2