RISKY BUSINESS: Compliance Risks of the Electronic Medical Records (EMR)

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AGENDA

- Pros and Cons
- Special Challenge Areas
- Case Studies
- Coding Paradigm Shift
- Documentation Ideas to Prevent Fraud and Abuse
- Promoting Oversight and Audit
RISKY BUSINESS: Compliance Risks of the Electronic Medical Record (EMR)
Paperless Office

- Paperless
- Less time searching for charts
- No illegible handwriting
- Lessen the possibility of error
- Storage and record retrieval eased

Incentives

- Possible discount on malpractice insurance
- Lessen the possibility of error
- Subsidies from government
- Subsidies from providers
- Cost Efficiency
Patient Care and Access

• Coordination of Care

• Patient Access to Health Records
  – Google
  – Microsoft

Privacy, Security, and Regulatory Conflicts

• Hacking.
• Intentional and Accidental - Worldwide.
• The Certification Commission for Healthcare Information Technology (CCHIT) and HIPAA requirements conflict.
Certification / Template Issues

- Lack of Certification Programs for EMR Users
  - Training
- Documentation Problems
  - Rigid Templates
  - “Smart” Sets, Text, Phrases
  - Templates for Complete Documentation of Encounter and related procedures or tests.

Smart Sets and Free Text

- EMR vendors are convinced that medical histories can be recorded using the point and click technique, however some practitioners disagree.
  - “The medical history is a narrative, a record of a fluid, and sometimes meandering dialogue between patients and physicians. The history probes in all directions, it wanders, it creates new passageways. The patient’s response to a question often opens up a new avenue of inquiry, a function that cannot be reproduced on a template (Michael Kirsch, MD).”
Special Challenges

Copy and Paste
Cut, Copy, and Paste Risks

- Inaccurate/outdated information may adversely impact patient care
- Inability to identify author and their thoughts
- Inability to identify when the documentation was created
- Inability to accurately support/defend E&M codes

Cut, Copy, and Paste Risks

- Propagation of false information
- Internally inconsistent progress notes
- Unnecessarily lengthy progress notes
- If provider documentation functionality such as copy is used appropriately, the functionality can assist providers in working efficiently while maintaining optimal care and compliant documentation.
Cut, Copy, and Paste Risks

• Stephen Levinson, MD, warns that “speed is not the same as efficiency, which requires tools that help physicians work quickly while maintaining optimal care and compliant documentation.”
  

Cut, Copy, and Paste Risks

• Copy may be appropriate when information is:
  – Based on external/ independently verifiable sources
  – Clearly and easily distinguished from original information, such as automatic summaries that populate data fields that are clearly identified as non-original and cannot be mistaken for original information
  – Not actually rendered as part of the record until after a re-authentication process and is auditable for identifying actual origination
Coding, Documentation, Billing Problems

• Presently there has been no official directive or comment from the Centers for Medicare and Medicaid Services (CMS).
• Much has been written about copy notes from the local (state) Medicare carriers.
  – “Cloning of documentation will be considered misrepresentation of the medical necessity requirement for coverage of services. Identification of this type of documentation will lead to denial of services for lack of medical necessity and recoupment of all overpayments made (Cigna Medicare Idaho).”

Coding, Documentation, Billing Problems

• Documentation of medical necessity is proof that the diagnostic tests, services rendered, treatments provided, or procedures conducted were ordered appropriately based on the patient’s illness, injury, prevention of diseases, or other patient specific needs.
• Documentation of medical necessity of a service is the criteria for payment in addition to the individual requirements in selecting the appropriate level of code assignment.
Case Study A

- Mary Lillamb presents to a hospital emergency room for a laceration. While washing dishes this 35-year-old female cut her hand on a knife in the dishwater. She presents to the ED, is triaged, and moved to examination room 1. Following evaluation from the physician, the patient receives 10 sutures with instructions to follow up in 10 days for suture removal. The physician documents his emergency room encounter for this visit, including a complete history and physical and system evaluation.

In 10 days the patient returns with no complaints and her sutures are removed. The physician examines the patient and finds no signs of infection and instructs the nurse to remove the stitches. The physician then pulls up his prior ED note, highlights the history and physical and system evaluation sections, and copies that information into the new visit history. The ED coder reviews the documentation and bills for a Level 3 ED visit.
Case Study A

- **Observation**: The first visit was reported consistent with facility E/M guidelines.
- However, the second encounter was inappropriately reported at the same level as the first visit because the physician pulled forward documentation of services that were not actually performed on the second encounter.
- The ED coder could not determine that the documentation within the record was from a previous encounter.
Authorship Integrity

- Inaccurate representation of authorship of documentation
- Duplication of inapplicable information
- Incorporation of misleading/wrong documentation due to loss of context for users available from the original source
- Ability to take over a record and become the author
- Inclusion of entries from documentation created by others without their knowledge or consent

Authorship Integrity

- Inability to accurately determine services and findings specific to a patient’s encounter
- Inaccurate, automated code generation associated with documentation
Extended Exploding Notes

- Any software that allows you to check a box and get "a sentence" which could be the "same sentence" every time must be audited.
- Any software which automatically assigns codes, like E&M codes which cannot consider medical necessity and word pertinence must be audited.
- Great Idea - Don’t implement non-editable canned statements linked to check boxes.
Templates – Necessary but Risky

- Automated insertion of clinical data
- Templates provide clinical information by default and design
- All templates and auto-generated entries are potentially problematic
- Beneficial feature of EHR is auto population of discrete clinical data

Templates – Necessary but Risky

- Problem list maintenance is inconsistent
- Despite intentions, visits look identical
- Canned phrases and sentences cause the EMR to lose its uniqueness
- Duplicative and repetitive statements lack an “ease of reading” and can cause information to be misconstrued
**Templates – Necessary but Risky**

- Subjective observations go undocumented
- Sometimes they increase documentation and a risk of higher coding by necessity of checking boxes to close out screens

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**Case Study B**

- "I think the Department of Health needs to put out a warning to physicians that they need to look at their programs' default settings," West Palm Beach dermatologist Steven P. Rosenberg said a recent board meeting *Palm Beach Post*.
- “This year we have seen as many if not more medical records violations from electronic medical records as we saw from hand-written records violations.”
Case Study B

- Dr. Rosenberg spoke of a woman not knowing for four years that she had had abnormal Pap smears because the EMR used by her physician defaulted to an old test result that was in the normal range.
- The woman, who testified at the board meeting, eventually needed a hysterectomy after she developed cancer and will never be able to have children.

Case Study C

- Dr. Rosenberg states that in another case where the record of a woman with a hysterectomy said she had a normal cervix. She in fact didn't have a cervix anymore.
- Dr. Rosenberg clarified his remarks in an interview with Healthcare IT News by saying that he's “not against EMRs and not against government incentives that would improve healthcare, but believes that there needs to be more research on the efficacy and risks
Case Study C

- of using EMRs before the federal government shells out billions to help physicians adopt electronic systems.
- “Government agencies need to do more due diligence to make sure programs are going to be worth the investment,” he explained.
How Does the EMR Affect Coding?

- Auditing firms found that coding staff did the following:
  - Used a coding queue of the EMR to hold claims based on risk areas
  - Claim Scrubber software utilized in addition to EMR
  - In some entities, the coding auditors were not separated from coders working denials
  - One to two minimal audits done by provider

How Does the EMR Affect Coding?

- Randomly pulled prospective sample from schedule and held in coding audit queue
- Report to providers
- Trending done of utilization, not of coding audit results
Case Study C – EMR Coder

- In a Kaiser Permanente study, the MD documents in EMR and codes are embedded in EMR display names with no fee ticket
- Embedded codes auto-adjudicate – no review by coder prior to claim submission to insurance company
- Claim goes to Insurance company: Pay/Deny
- Denied Claims go back to coder to clarify /addend/query
- MD has become the “default coder”

Case Study C – EMR Coder

- EMR forced docs to “code” as codes were embedded in diagnosis/procedures names
- Doctors as “Default coders” = SCARY!
- Need to educate to impact the 10,000 visits a day rather than stop in a work queue and fix
- Coders that are comfortable/knowledgeable enough to audit/educate physicians are a rare breed
Case Study C – EMR Coder

• As an HMO with waivers for coding, the company was extremely lacking in expertise.

• Their baseline accuracy was poor:
  – Diagnosis Accuracy = 75%
  – Level of Service (LOS) = 52%
  – Procedure = 82%

• Kaiser implemented some changes to provides solutions for their coding problems around the EMR.

Case Study C – EMR Coder

• Clinic based department specific coders doing onsite auditing and feedback

• Monthly 20 minute 1:1 educational feedback session for each of 1,000 providers in the region

• Found and trained coders to be the face of coding to embed in the clinical departments

• Staff to a 1:40 coder to clinician ratio

• 10 Charts per month audited
Case Study C – EMR Coder

- Celebrated 95% accuracy in diagnosis, E&M and procedure coding for Colorado region (April 2010)
- Now focus is Bell Curve distribution of codes
  - Why are 2 docs 95% accurate, they do similar work but one has Level 1’s and another Level 5’s
- Inpatient Documentation Improvement started
- Disease Definition/Specificity Education
- Higher coder job satisfaction

Ideas to Prevent Fraud and Abuse
Organizational Commitment

- Establish organization-wide policies for use of EMR in a lawful, ethical, and regulatory manner. These might include items such as:
  - Prohibiting the entry of false information into any of the organization’s records
  - Defining individual responsibility and accountability for the accuracy and integrity of information
  - Specifying consequences for the falsification of information

Organizational Commitment

- Training regarding EMR falsification/security

- Organizations should also establish EMR and HIM-related policies such as:
  - Specifying administrative documentation requirements
  - Specifying clinical documentation requirements
  - Requiring the logging of activity on EMR systems
  - Covering changes (i.e., corrections and amendments) to records
Organizational Commitment

- Organizations must establish a process for logging of all activity on EHR systems which would. This would include:
  - Determining which logging features should be used
  - Enabling system logging
  - Assigning responsibility for auditing of log entries and reported exceptions
  - Defining retention periods and procedures for log records

EMR Educational Program

- Establish and maintain an education program.
- The program must be designed to communicate:
  - the organization’s policies,
  - the individual’s responsibilities, and
  - the capabilities and functions of the EMR system to each individual who works with EMRs
EMR Educational Program

- Educational Objectives might be as follows:
  - Explain responsibilities for maintaining the integrity and accuracy of information:
    - Personal responsibility for protecting system access information
    - Personal responsibility for creating accurate records
    - Responsibility to notify management of problems that are discovered
  - Cover the proper use, features, and functions of the EMR system.

- Educational Objectives might be as follows:
  - Address methods for preventing erroneous entry of information and the importance of preventing errors.
  - Cover penalties for falsifying any organizational records.
  - Provide instruction on how to use the system security features to prevent unauthorized access to systems.
  - Inform all EMR users that their activities are being logged by the system.
EMR Educational Program

• Further reference should be made to various federal and state legislation and the requirements of various oversight agencies:
  – Federal False Claims Act
  – HIPAA
  – Deficit Reduction Act of 2005

EMR Educational Program

• Further reference should be made to various federal and state legislation and the requirements of various oversight agencies:
  – CMS Conditions of Participation
  – JCAHO Accreditation Requirements
  – AOA Accreditation Requirements
  – AAAHC Accreditation Requirements
  – Medical Staff Bylaws of the Organization
Promoting Oversight and Audit

The Stakeholders

- Who needs to be involved in the audit of the EMR?
  - HIM or Medical Records
  - Coding personnel
  - Information Systems/Technologies
  - Physicians
  - Executive Leadership
  - Compliance
  - You may want to consider:
    - PFS / Finance
Audit Scope and Objective

- Annual risk assessment
- Meet with senior leadership and key EMR process owners
- What are the key factors increasing the EMR risk profile?
  - Technological
  - Behavioral (user)
- Any specific areas of concern

Research and Data Collection

- Obtain & review the following:
  - Policies and procedures related to the EMR
  - Existing documentation and process flows
  - Provider training materials
  - Electronic data – patient encounter information (DOS, CPT, Dx (primary/secondary))
    - Sampling
    - Trending analysis
Case Study D

• An IT employee installed a planned “Windows update” to the hospital’s networking hardware that morning which shut down access to physicians in hospital-based ambulatory offices.

• The offices activated their paper-based downtime plans, but many patient safety issues were encountered. For example, physicians were solely dependent on the patient’s recollection of allergies because they had no access to allergies recorded in the EMR.

Case Study D

• A process was developed “on-the-fly” to use a laptop with mobile broadband connectivity to access the EMR, but before these were ready the original problem was resolved.

• Hardware and software technology problems will occur, but most are preventable and can be minimized with proactive IT management

• Physicians are responsible for developing “downtime plans” of how the office will safely care for patients when the EMR is unavailable
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