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Compliance Risks in the Electronic Medical Record

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We've come a long way – or have we?

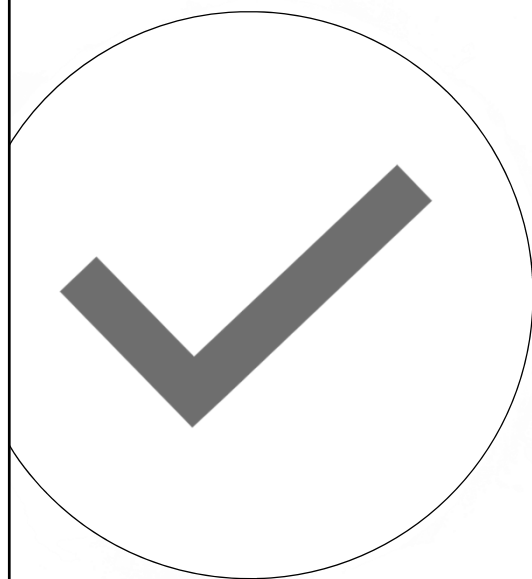
“By computerizing health records, we can avoid dangerous medical mistakes, reduce costs, and improve care.”

President George W. Bush,
State of the Union Address
January 20, 2004

Issues

- Is meaningful use really meaningful?
- Is information available between entities?
- Is the quality of care improved – or even maintained?
- Is the health information secure?
- **Are medically necessary services provided, documented, billed for, and reimbursed appropriately?**

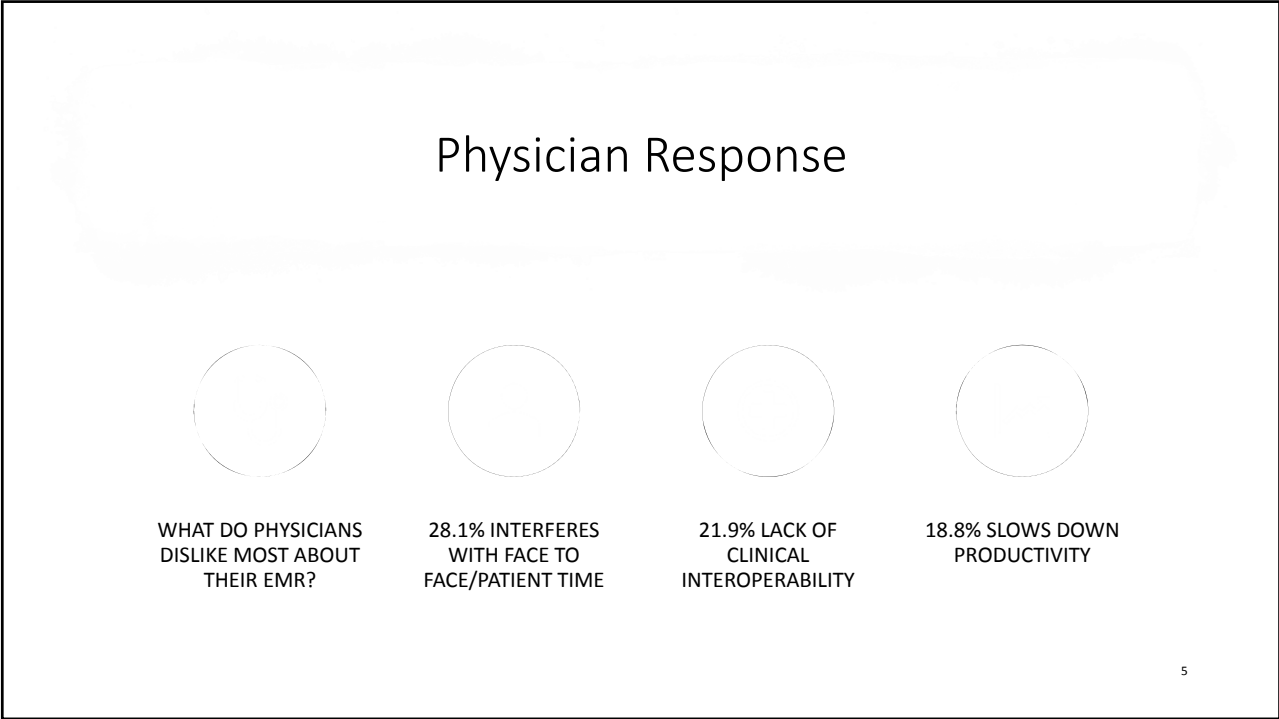
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Balancing Medical Necessity and Meaningful Use

- Bringing forward medical history in an EMR is an important aspect of meaningful use
- Does this mean that you can count that comprehensive history toward the level of service for every encounter now and forevermore?
- What about medical necessity of elements? For example, vitals on every patient?

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Physician Response

Study: What Do Physicians Read (and Ignore) in Electronic Progress Notes?

- Most attention given to Impression and Plan
- Very little attention given to vital signs, medication lists, and laboratory results

“Optimizing the design of electronic notes may include rethinking the amount and format of imported patient data as this data appears to largely be ignored.”

Applied Clinical Informatics
<http://aci.schattauer.de/en/home/issue/special/manuscript/21088/show.html>

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Concerns with electronic records and overcoding

The Center for Public Integrity –
September 2012

“coding levels may be accelerating in part because of increased use of electronic health records...”

“easy to create detailed patient files with just a few clicks”

“longer and more complex visits are easier to document”

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It's a New World

Paper Records: Not documented, not done.

Electronic Records: You documented it, but did you really do it?

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Sebelius-Holder Letter

September 24, 2012

“False documentation of patient care is not just bad patient care; it’s illegal. The indications include potential ‘cloning’ of records in order to inflate what providers get paid.”

<http://www.nytimes.com/interactive/2012/09/25/business/25medicare-doc.html>

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Congressional Response

October 4, 2012 letter to HHS Secretary Sebelius

“...your EHR incentive program appears to be doing more harm than good.”

Request –

- Suspension of EHR bonus payments and delay penalties for providers who don’t use EHR
- Increase what’s expected of meaningful users
- Block business practices that prevent exchange of information

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OIG Workplan for 2012

“We will assess the extent to which CMS made potentially inappropriate payments for E/M services 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 based upon the content of the service and have documentation to support the level of service reported.”

OIG 2016 Compendium of Unimplemented Recommendations

This recommendation relates to our Top Management Challenge

Meaningful and Secure Exchange and Use of Electronic Information and Health IT

Expected Impact

Improved program integrity
protecting beneficiaries' personal identifying information

HEALTH INFORMATION TECHNOLOGY

Not All Recommended Fraud Safeguards Have Been Implemented in Hospital EHR Technology

RECOMMENDATION

ONC and CMS should collaborate to develop a comprehensive plan to address fraud vulnerabilities in electronic health records (EHR).

OUR OBJECTIVE was to determine how hospitals that received EHR Medicare incentive payments, which are administered by CMS, had implemented recommended fraud safeguards for EHR technology. We found that nearly all hospitals with EHR technology had RTI International (RTI)-recommended audit functions in place, but they may not be using them to their full extent. We also found that nearly all hospitals were using RTI-recommended data transfer safeguards, and all hospitals employed a variety of RTI-recommended user authorization and access controls. ONC, which coordinates the adoption, implementation, and exchange of EHRs, contracted with RTI to develop recommendations to enhance data protection; increase data validity, accuracy, and integrity; and strengthen fraud protection in EHR technology.

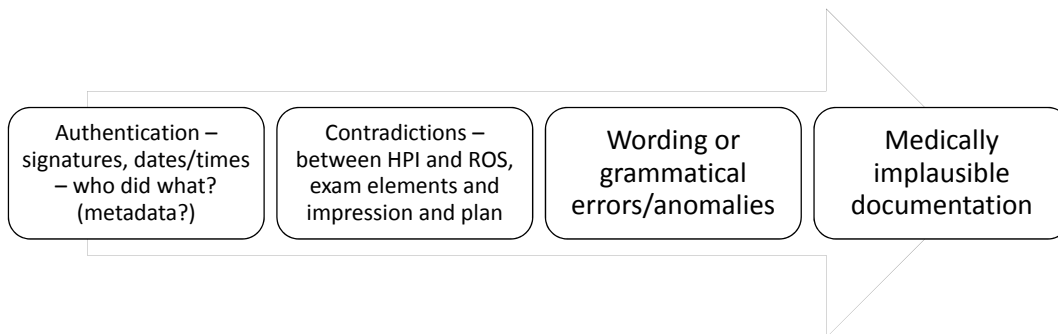
We found that only about one-quarter of hospitals had policies regarding the use of the copy-paste feature in EHR technology, which, if used improperly, could pose a fraud vulnerability.

Implementation Status

CMS and ONC concurred with the recommendation. CMS stated that it continues to work with ONC to develop a comprehensive plan to detect and reduce fraud. CMS also stated that it is conducting prepayment audits as well as prepayment edit checks. Although we acknowledge the usefulness of conducting audits and prepayment checks as a strategy to detect fraud and abuse, these efforts do not address our recommendation to work with ONC on strengthening its collaborative efforts. ONC stated that it is committed to providing technical assistance to Federal agencies that have health care fraud enforcement authority. ONC believes that all divisions of the Department have a shared responsibility for the integrity of departmental programs, regardless of whether they have health care fraud enforcement authority.

Report: OEI-01-11-00570 - December 2013

What are the auditors looking for?




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Code Generators


- Is the coding software programmed for the 1995 or 1997 Documentation Guidelines?
- Has the coding software been programmed to account for medical policies specific to the local Medicare contractor?
- How does the coding software manage dictated portions of the encounter such as History of Present Illness?
How does the coding software distinguish between the levels of medical decision-making?

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
Templates



Is the provider able to choose only part of a template or to personalize a template?



Are there multiple templates, personalized for complaint or diagnosis?



Are the various contributors to the encounter identified?
Nursing staff, physician, etc.

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Cloned Notes

“Documentation is considered cloned when each entry in the medical record for a beneficiary is worded exactly like or similar to the previous entries. Cloning also occurs when medical documentation is exactly the same from beneficiary to beneficiary. It would not be expected that every patient had the exact same problem, symptoms, and required the exact same treatment.

First Coast Service Options, Medicare Part B newsletter 2006
(Definitions published by Medicare contractors as early as 1999.)

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Cloned Notes

November/December 1999 Medicare Bulletin:

“Cloned notes are notes that have little or no change from day to day and patient to patient. These types of notes do not support the medical necessity of a visit. More importantly, in some cases, they may not actually support that a visit occurred. Cloned notes may be construed as an attempt to defraud the Medicare program.”

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Cloned Documentation

Whether the documentation was the result of an Electronic Health Record, or the use of a pre-printed template, or handwritten documentation, cloned documentation will be considered misrepresentation of the medical necessity requirement for coverage of services due to the lack of specific individual information for each unique patient. Identification of this type of documentation will lead to denial of services for lack of medical necessity and the recoupment of all overpayments made.

- NGS Medicare -

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Copy and Paste

AHIMA Position Statement – March 17, 2014

Called on industry stakeholders, EHR system developers, the public sector, and healthcare providers to work together to implement standards for the appropriate use of copy and paste

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Why copy and paste?

“...most physicians use the functionality simply to save time. They have not been given the time and training needed to become fully proficient with their new systems, so they create workarounds to help them get through their day.”

Heather Haugen, PhD

“Overcoming the Risks of Copy and Paste in EHRs”

Journal of AHIMA, June 2014

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June 2014 – JAMA Internal Medicine – University of Wisconsin School of Medicine and Public Health and the University of Wisconsin Hospital and Clinics:

- “it is too easy, and often mistaken, to equate a physician’s routine use of copy-and-paste with fraud. Data replication is a feature of electronic health records; facts beyond the mere use of duplicated text are required to establish that a note may be fraudulent.”
- It can be efficient and clinically useful when used properly, and that EHRs are “not to blame for the carelessness of individual physicians.”

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Issues with Copy and Paste

- Outdated or redundant information
- Inability to identify the author or date of origin of information
- Unnecessarily lengthy notes
- Appearance of fraudulent activity – e.g., billing twice for the same “work”
- Quality of care and medico-legal integrity are compromised

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Identifying Copy and Paste

“Electronic health records (EHRs) allow physicians writing these notes to supplement traditional manual data entry with copied or imported text. However, copying or importing text increases the risk of including outdated, inaccurate, or unnecessary information, which can undermine the utility of notes and lead to a clinical error.”

- Study – inpatient progress notes – UCSF – January – August 2016
 - 18% manually entered
 - 46% copied
 - 36% imported
- Software tools to identify copy and paste – EPIC

Michael D. Wang, MD, Raman Khanna, MD, and Nader Najafi, MD *Characterizing the Source of Text in Electronic Health Record Progress Notes*, JAMA Intern Med. Published online May 30, 2017. doi:10.1001/jamainternmed.2017.1548

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General Principles of Medical Record Documentation

1. The medical record should be complete and legible.
2. The documentation for each patient encounter should include:
 - Reason for the encounter and relevant history, physical examination findings and prior diagnostic test results
 - Assessment, clinical impression or diagnosis
 - Plan for care
 - Legible identity of the observer

From CMS Evaluation and Management Documentation Guidelines – stated to be applicable to all types of medical and surgical services in all settings.

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3. If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.
4. Past and present diagnoses should be accessible to the treating and/or consulting physician.
5. Appropriate health risk factors should be identified.
6. The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented.
7. The CPT and ICD codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.

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Evaluation and
Management

Key Components

- History
- Examination
- Medical Decision-Making

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History

- **DG: The CC, ROS and PFSH may be listed as separate elements of history or they may be included in the description of the history of the present illness.**
- **DG: A ROS and/or a PFSH obtained during an earlier encounter does not need to be re-recorded if there is evidence that the physician reviewed and updated the previous information. This may occur when a physician updates his or her own record or in an institutional setting or group practice where many physicians use a common record. The review and update may be documented by:**
 - *describing any new ROS and/or PFSH information or noting there has been no change in the information; and*
 - *noting the date and location of the earlier ROS and/or PFSH.*

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History

- **DG: The ROS and/or PFSH may be recorded by ancillary staff or on a form completed by the patient. To document that the physician reviewed the information, there must be a notation supplementing or confirming the information recorded by others.**
- **DG: If the physician is unable to obtain a history from the patient or other source, the record should describe the patient's condition or other circumstance which precludes obtaining a history.**

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History

- **DG: The medical record should clearly reflect the chief complaint.**

The HPI is a chronological description of the development of the patient's present illness from the first sign and/or symptom or from the previous encounter to the present. It includes the following elements:

- location,
- quality,
- severity,
- duration,
- timing,
- context,
- modifying factors, and
- associated signs and symptoms.

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History of Present Illness

Extended History of Present Illness

- **DG: The medical record should describe at least four elements of the present illness (HPI), or the status of at least three chronic or inactive conditions. (1997 Guidelines)**

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History of Present Illness

Who must document the History of Present Illness?

DG: The ROS and/or PFSH may be recorded by ancillary staff or on a form completed by the patient. To document that the physician reviewed the information, there must be a notation supplementing or confirming the information recorded by others.

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History – Review of Systems

- ***DG: At least ten organ systems must be reviewed. Those systems with positive or pertinent negative responses must be individually documented. For the remaining systems, a notation indicating all other systems are negative is permissible. In the absence of such a notation, at least ten systems must be individually documented.***

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History – Past, Family, Social

- **DG: At least one specific item from two of the three history areas must be documented for a complete PFSH for the following categories of E/M services: office or other outpatient services, established patient; emergency department; domiciliary care, established patient; and home care, established patient.**
- **DG: At least one specific item from each of the three history areas must be documented for a complete PFSH for the following categories of E/M services: office or other outpatient services, new patient; hospital observation services; hospital inpatient services, initial care; consultations; comprehensive nursing facility assessments; domiciliary care, new patient; and home care, new patient.**

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Examination

1995 – Organ Systems/Body Areas

1997 – Specific bullet points in each Organ System

Many EMR templates based on 1997 bullets, but are all those elements really performed?

Is the exam related to the presenting problem?

One click to document a completely, normal comprehensive examination?

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Medical Decision-Making

- **DG: For each encounter, an assessment, clinical impression, or diagnosis should be documented. It may be explicitly stated or implied in documented decisions regarding management plans and/or further evaluation.**
 - For a presenting problem with an established diagnosis the record should reflect whether the problem is: a) improved, well controlled, resolving or resolved; or, b) inadequately controlled, worsening, or failing to change as expected.
 - For a presenting problem without an established diagnosis, the assessment or clinical impression may be stated in the form of differential diagnoses or as a "possible", "probable", or "rule out" (R/O) diagnosis.

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Medical Decision-Making

- **DG: The initiation of, or changes in, treatment should be documented. Treatment includes a wide range of management options including patient instructions, nursing instructions, therapies, and medications.**
- **DG: If referrals are made, consultations requested or advice sought, the record should indicate to whom or where the referral or consultation is made or from whom the advice is requested.**

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Medical Decision-Making

- **DG: If a diagnostic service (test or procedure) is ordered, planned, scheduled, or performed at the time of the E/M encounter, the type of service, eg, lab or x-ray, should be documented.**
- **DG: The review of lab, radiology and/or other diagnostic tests should be documented.** A simple notation such as "WBC elevated" or "chest x-ray unremarkable" is acceptable. Alternatively, the review may be documented by initialing and dating the report containing the test results.

NOTE: This is not acceptable documentation for billing for the professional interpretation of X-rays or other diagnostic services.

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Medical Decision-Making

- **DG: A decision to obtain old records or decision to obtain additional history from the family, caretaker or other source to supplement that obtained from the patient should be documented.**
- **DG: Relevant findings from the review of old records, and/or the receipt of additional history from the family, caretaker or other source to supplement that obtained from the patient should be documented.** If there is no relevant information beyond that already obtained, that fact should be documented. A notation of "Old records reviewed" or "additional history obtained from family" without elaboration is insufficient.

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Medical Decision-Making: Risk

- **DG: Comorbidities/underlying diseases or other factors that increase the complexity of medical decision making by increasing the risk of complications, morbidity, and/or mortality should be documented.**
- **DG: If a surgical or invasive diagnostic procedure is ordered, planned or scheduled at the time of the E/M encounter, the type of procedure, eg, laparoscopy, should be documented.**
- **DG: If a surgical or invasive diagnostic procedure is performed at the time of the E/M encounter, the specific procedure should be documented.**
- **DG: The referral for or decision to perform a surgical or invasive diagnostic procedure on an urgent basis should be documented or implied.**

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Time-Based Coding

- **DG: If the physician elects to report the level of service based on counseling and/or coordination of care, the total length of time of the encounter (face-to-face or floor time, as appropriate) should be documented and the record should describe the counseling and/or activities to coordinate care.**

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Time – Counseling and Coordination of Care

Medicare Claims Processing Manual – Chapter 12, Section 30.6

- The code selection is based on the total time of the face-to-face encounter or floor time, not just the counseling time. The medical record must be documented in sufficient detail to justify the selection of the specific code if time is the basis for selection of the code.
- The duration of counseling or coordination of care that is provided face-to-face or on the floor may be estimated but that estimate, along with the total duration of the visit, must be recorded when time is used for the selection of the level of a service that involves predominantly coordination of care or counseling.

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Physician Proposed Rule for 2019 – Potential changes to E/M

- CMS wants to take the focus off history and exam and put it on medical decision-making and time spent with patient.
 - Options for billing based on time - even if the visit is not dominated by counseling and coordination of care.
- Physicians in same group practice and same specialty could now bill multiple E&Ms the same day - recognizing that physicians have different areas of expertise, even though they have the same specialty designation.
- For established patients, physicians would only have to document information that has changed and not re-document previous information.
- Likewise, physicians would not have to re-document info documented by others - (Think HPI!)
- 50% reduction in E&M same day as office procedure.

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Physician Proposed Rule for 2019 – Potential Changes to E/M

- The current E&M coding structure would remain, but there would be a single fee paid for levels 2-5, that fee being somewhere in between the current rate for a 3 and 4.
- One rate for new patients, one rate for established - that's it!
- Providers would still bill the appropriate level, but the reimbursement would be the one rate.
- Reviewers would review just to make sure you met at least a level 2 but not look for anything more, even if the provider billed a higher level - because the documentation would support that level of reimbursement.

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Surgical Procedures

The Joint Commission and other accrediting agencies address standards for surgery documentation in hospital setting

- Who sets standards for in-office procedures?

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Procedures

Office Procedures

- Sometimes documented as orders or CPT description without details of the procedure performed

EX: "20610 - Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); without ultrasound guidance"

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Procedure Documentation

Procedure:

We reviewed the procedure of joint aspiration and injection and discussed the risks, benefits, and alternative treatments. Informed consent was obtained as outlined below. I verified that the patient had no allergies to local anesthetic. We discussed the potential side effects of corticosteroids, including but not limited to local tissue breakdown, elevation of blood sugar and seizures.

A procedural pause was conducted to verify correct patient identity, procedure to be performed, correct side and site, correct patient position, availability of implants, and need for special equipment or special requirements. After verification, the was marked and then prepped in the usual sterile fashion. Using a 22 gauge 1.5 inch needle, 4 mL of lidocaine and was injected into the joint space without difficulty. After injection, the joint was passively moved through the full range of motion and a sterile dressing was applied. The patient tolerated the procedure well. Aftercare discussed.

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Office Documentation

At a minimum:

- Document medical necessity
- Document specifics of procedure –
 - Site and length of laceration
 - Margins for lesion removal
 - Reason for lesion removal
 - Technique of procedure
- Details needed to support the code billed

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Diagnosis Coding

- Have the physicians been educated in diagnosis documentation?
- Has the diagnosis code listing been personalized for that practice and that physician?

As more physician payment mechanisms are based on severity of illness, correct and specific diagnosis coding becomes more important – to the physician.

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Examples of Diagnosis Coding Errors

- Incorrect/incomplete description entered in EMR
 - “intestinal obstruction”
K50.012 - Crohn's disease of small intestine with intestinal obstruction
 - “chronic insomnia”
F51.04 - Psychophysiologic insomnia
- Lack of physician knowledge of coding guidelines
 - Coding E11.9 – diabetes, unspecified in addition to E11.* codes for diabetes complications

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Code #s in Lieu of Diagnosis

Providers must specifically document the diagnosis, condition, and/or problem. It is not appropriate for providers to list the code # or select a code # from a list of codes in place of a written diagnosis.

Coding Clinic 4Q 2015

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Diagnosis Documentation

- How the provider documents the diagnosis matters
 - This information may be presented to patient on Visit Summary
- Does the diagnosis code description in the EMR reflect what the patient was told about their condition?

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Scribes

No CMS policy on scribes –

(other than the scribe DOES NOT have to sign the record)

- Noridian: If the physician uses a scribe (an individual taking notes), the scribe needs to fully sign the note, with their own credentials, followed by the physician's signature and credentials.
- WPS: "Scribe" situations are those in which the physician utilizes the services of his, or her, staff to document work performed by that physician, in either an office or a facility setting. In Evaluation and Management (E/M) services, surgical, and other such encounters, the "scribe" does not act independently, but simply documents the physician's dictation and/or activities during the visit. The physician who receives the payment for the services is expected to be the person delivering the services and creating the record, which is simply "scribed" by another person.

Beware of "Make Me The Author" functions

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CIGNA on Scribes

If a nurse or mid-level provider (PA, NP, CNS) acts as a scribe for the physician, the individual writing the note (or history or discharge summary, or any entry in the record) should note "written by xxxx, acting as scribe for Dr. yyy." Then, Dr. yyyy should co-sign, indicating that the note accurately reflects work and decisions made by him/her. **Note: The scribe is functioning as a "living recorder," recording in real time the actions and words of the physician as they are done. If this is done in any other way, it is inappropriate. This should be clearly documented as noted, by both the scribe and the physician. Failure to comply with these instructions may result in denial of claims.**

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Advanced Practice Providers: Incident-to

In order to bill services incident-to a physician (Medicare requirements):

- Employee of the physician
- Following a plan of care established by the physician
- Physician is in the office suite and immediately available

How do you support this in the EMR?

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Advanced Practice Providers: Split/Shared

“When a hospital inpatient/hospital outpatient or emergency department E/M is shared between a physician and an NPP from the same group practice and the physician provides any face-to-face portion of the E/M encounter with the patient, the service may be billed under either the physician’s or the NPP’s UPIN/PIN number. However, if there was no face-to-face encounter between the patient and the physician (e.g., even if the physician participated in the service by only reviewing the patient’s medical record) then the service may only be billed under the NPP’s UPIN/PIN.

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Advanced Practice Providers: Split/Shared

Compliant Documentation

- Identify which portions of the visit have been performed by the physician
- “Seen and agree” means no fee!
- Hospital dictation system may not allow APPs to document independently

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Care Management Services

Transitional Care Management – code is for 30 days of care for overall management of patient’s needs, including psychosocial needs

- Date the patient was discharged – include diagnoses/concerns – Discharge Summary?
- Communication with patient and/or caregiver within 2 business days
 - Where is phone call or other communication documented?
 - What if you can’t make contact? 2 documented attempts?
- Date of E&M visit
 - No specified documentation or level of service required other than moderate or high-complexity MDM must be supported
 - Medical necessity drives what is done/documented

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Care Management Services

Care Plan Oversight

- Documentation – log of time spent and activities performed to support 30 minutes or more
- Face-to-face visit within 6 months
 - Linking statement in time log?

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Care Management Services

Chronic Care Management

- Not a face-to-face service, so where will the documentation be located in the EMR?
- Time spent by clinical staff
- Issues –
 - every patient always requires 20 minutes
 - Generic care plan – not specific to patient's condition/needs

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Hospital Site of Service

Issues –

- Unable to determine reason for visit
- Visit documentation incomplete – no history/examination/diagnosis
- Run-on visits – documentation continuous from one day to the next

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Addenda

Are addenda done for the proper reasons and documented appropriately?

Medicare Program Integrity Manual, Chapter 3 – Section 3.3.2.5.B

“Regardless of whether a documentation submission originates from a paper record or an electronic health record, documents submitted to MACs, CERT, Recovery Auditors, and ZPICs containing amendments, corrections or addenda must:

1. Clearly and permanently identify any amendment, correction or delayed entry as such, and
2. Clearly indicate the date and author of any amendment, correction or delayed entry, and
3. Clearly identify all original content, without deletion. “

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Signatures

Medicare Program Integrity Manual, Chapter 3 – Section 3.3.2.4.E

“Providers using electronic systems need to recognize that there is a potential for misuse or abuse with alternate signature methods. For example, providers need a system and software products that are protected against modification, etc., and should apply adequate administrative procedures that correspond to recognized standards and laws. The individual whose name is on the alternate signature method and the provider bear the responsibility for the authenticity of the information for which an attestation has been provided. Physicians are encouraged to check with their attorneys and malpractice insurers concerning the use of alternative signature methods. “

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Finalizing the Documentation

Code Selection

- Is the physician able to override the code selected by the EHR?
- Can he/she override the code to a higher level or only to a lower level of service?

Signatures

- Is the provider able to sign off on multiple items with one “sign-off” – multiple encounters, test results, phone calls, prescriptions

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Timing of Billing

- Is the documentation complete before the encounter is billed?
- For ancillary services, is the bill “dropped” based when the order is entered or when the test is performed and results entered?

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“Charge Passing”

Codes chosen in EMR transmit directly to Practice Management system and are then billed

New concept in physician billing

Pressure for physicians to choose the correct codes at the time of the service

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When You Receive Request for Records

Review actual printed records before sending
May not appear the same on paper as on screen
Pertinent information, necessary to support codes, may not appear

May need to work with EMR vendor to ensure appropriate information is available to submit for review

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Resources

- <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/electronic-health-records.html>
- Appropriate Use of the Copy and Paste functionality in Electronic Health Records
<http://bok.ahima.org/PdfView?oid=300306>
- *Electronic Health Record Compliance Framework, Health Care Compliance Professional's Manual*
- CMS 2019 Proposed Rule –
<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1693-P.html>

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