HCCA's 12TH ANNUAL COMPLIANCE INSTITUTE

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Auditing Electronic Medical Records

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A whole new world!

Compliance Auditors are now looking for something different… there won't be issues like "finding the paper record" or "illegibility"

Instead there are a whole new set of issues!

- Copy/Paste or "Cloning"
- Electronic Teaching Physician attestations macros
- Pre-populated information
- Pre-formatted text

Copy/Paste

Methods-

- Word document “copy/paste” function
- “Copy note forward” option
- Save note as template option

You have to know what your system can do and what your providers are doing with it! (and you have to have the system access to be able to see it!)

Outpatient Example- First Note

Patient is a 65 year old male who is here today for follow up of hypertension. Patient complains today of swelling. Symptoms are gradually worsening. Patient denies blurred vision, chest pain, dizziness, nausea, numbness, severe headache, swelling, vomiting, weakness and weight loss. Patient reports adherence to medication(s). and Patient admits excessive salt intake. Patient does not self monitor blood pressure. He has hyperlipidemia and takes Lipitor 10
He had CHF in 1995. He has had swelling of his legs for 1 week. He sleeps in a recliner. He denies breathing problems. Klhis edema resolved with lasix 20
He ahs CAD and had CABG in 1990
He had prostate cancer treated with radiation in 1996. He now gets Lupron q 4 months.He has osteoarthritis and has had a R knee fusion
He hasGERD and takes Protonix 40.

Patient reports his L kidney is nonfunctional. His BUn is 36 and his creatinine is 2.10

His potassium is high at 5.8. He tkes lisonpril and eats banannas
He is anemic and his hgb is 12.8

Outpatient Example- First Note-History

Past Medical History:
TM JOINT DISORDER NOS
BENIGN HYPERTENSION
LEFT HEART FAILURE 45-50% diastolic dysfunction
CORON ATHEROSCL VEIN BYPASS GRFT
: s/p cabg svg graft, occlusion cath 2000
ESOPHAGEAL REFLUX
MIXED HYPERLIPIDEMIA
MALIGN NEOPL PROSTATE Comment: s/p xrt 199 , now with lupron shots
GENERAL OSTEOARTHROSIS
s/p r knee tka
No past surgical history on file.

Outpatient Example- First Note- ROS

Constitutional: negative.
Eyes: negative.
Ears: negative.
Nose/Sinuses: negative.
Mouth/Throat: negative.
Neck: negative
Cardiovascular: negative.
Respiratory: negative.
Gastrointestinal: reflux.
Genitourinary: + urinary frequency and incontinence; he takes oxybutinin5mg
Musculoskeletal: swelling.
Skin: negative.
Neuro: negative.
Psych: negative.
Endocrine: negative.
Hem/Lymph: negative.

Outpatient Example- First Note- Physical Exam

BP 161/59 | Pulse 54 | Wt 180 lbs (81.647 kg)BP 140/70 by me

General: alert, oriented times three, no apparent distress, appearing age appropriate.
Skin: skin color, texture and turgor are normal.
Head: normocephalic, no masses, lesions, tenderness or abnormalities.
Eyes: anicteric sclera, pupils are equally round and reactive to light, extraocular movements are intact.
Ears: external ears normal, canals clear, tympanic membranes normal.
Nose: nares normal, septum midline, mucosa normal.
Oropharynx: normal, clear without erythema or exudate.
Neck: neck supple, no adenopathy, normal size, no bruits.
Chest: symmetric, no deformities, no chest wall tenderness and midline scar.
Lungs: percussion normal, good diaphragmatic excursion, lungs clear to auscultation bilaterally.
Heart: regular rate and rhythm, no murmurs, gallops or rubs.
Abdomen: abdomen soft, non-tender, nondistended, normal active bowel sounds, no masses or organomegaly.
Back: negative findings: no costovertebral angle tenderness.
Extremeties/Musculoskeletal: R knee fused; no pitting edema

Outpatient Example- First Note- Assessment/Plan

401.1 BENIGN HYPERTENSION
428.1 LEFT HEART FAILURE
414.02 CORON ATHEROSCL VEIN BYPASS GRFT
276.7 HYPERPOTASSEMIA
782.3 EDEMA
185 MALIGN NEOPL PROSTATE
715.00 GENERAL OSTEOARTHROSIS
587 RENAL SCLEROSIS NOS
285.9 ANEMIA NOS

PLAN

Follow up as written. Disposition: Return in about 7 days
Medications as ordered.
Labs as ordered
Usg kidneys

Outpatient Example- First Note- Addendum/Nurse Note

Addended Quiick Note:

Abnormal Labs

Uric acid is normal at 6.7
Sodium is high at 148
BUN is high at 38 and creatinine is high at 2.10
Urinalysis shows protein
Microalbumin is high at 7327

Addended
Quick Note:

His future orders for folate, iron, B12 etc don't seem to have been drawn.
Please get these done

Addended
Quick Note:

Chest xray shows the lungs to be mildly hyperinflated, but they are clear

Nurse Visit Note
Here today for 1 wk f/u, on leg swelling much improved today.

Date of last flu shot 2006
Date of last Pneumovax shot yes

Outpatient Example- Second Note

Patient is a 65 year old male who is here today for follow up of hypertension. Patient complains today of swelling. Symptoms are gradually worsening. Patient denies blurred vision, chest pain, dizziness, nausea, numbness, severe headache, swelling, vomiting, weakness and weight loss. Patient reports adherence to medication(s). and Patient admits excessive salt intake. Patient does not self monitor blood pressure. He has hyperlipidemia and takes Lipitor 10
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He hasGERD and takes Protonix 40.

Patient reports his R kidney is nonfunctional. His BUn is 36 and his creatinine is 2.10

His potassium is high at 5.8. He tkes lisonpril and eats banannas

He is anemic and his hgb is 12.8 **he has not done anemia studies**

Outpatient Example- Second Note- History

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BENIGN HYPERTENSION
LEFT HEART FAILURE

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587 RENAL SCLEROSIS NOS
285.9 ANEMIA NOS

Follow up as written. Return in about 2 months
Medications as ordered.
Labs as ordered
Avoid NSAIDS

Outpatient Example-Second Note-Addendum/Nurse's Note

Quick Note: Abnormal Labs

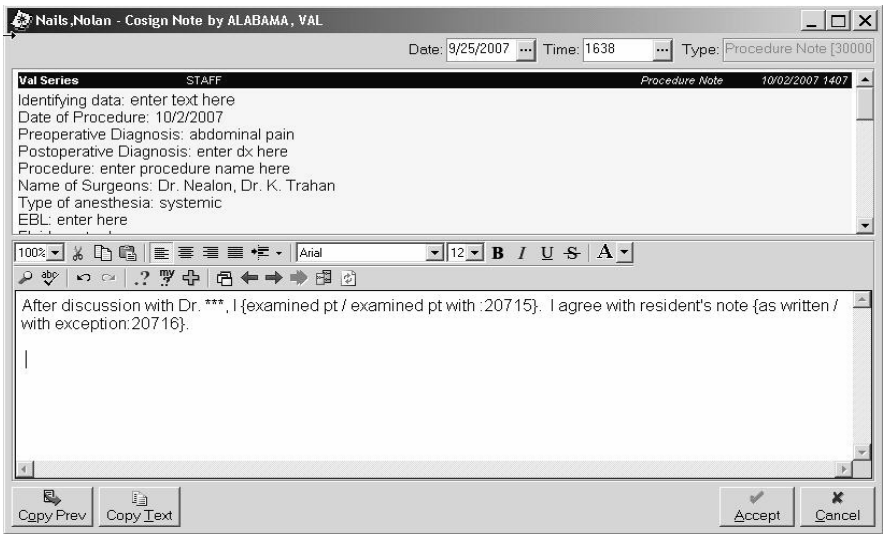
Iron is low normal at 54
TIBC is good at 305, but sat is low at 18
Potassium is high at 5.5
Chloride is high at 111
BUN is high at 25
B12 is good at 345
Folate is good at 15.9

Nurse Note
Here today for f/u and complains of chest pain

Other Examples

- Patient admitted and intubated… for 5 days the note states that the patient was intubated… the patient was actually extubated on day 3.
- The patient was admitted in critical condition and was inpatient for 10 days… each day the documentation states that the patient was critical… the patient was discharged on day 10.
- Patient was seen in outpatient clinic for 4 visits over the course of 5 months… each visit documents performance of a pap smear.

Teaching Physician Attestations- .attest



Additional Teaching Physician Attestations

- **.ATTESTINPATIENT** - I personally examined the patient on *** and agree with the resident's note {AS WRITTEN/WITH ADDITION(S):22506} by Dr. ***, on ***. I actively participated in the decision-making process. Please see the resident's note for additional details.
- **.ATTESTCOUNSELINGCOORDINATINGCARE** - I spent *** {MINUTES/HOURS:20240} total time with the patient today. Of that time, *** {MINUTES/HOURS:20240} was spent on exam (see notes) and *** {MINUTES/HOURS:20240} was spent counseling the patient regarding {COUNSELING OPTIONS:30349}. *(counseling options include: 1) surgical options 2) treatment options 3) risks and benefits of treatment 4) ***)*
- **.ATTESTCRITICALCARE** - I spent *** {MINUTES/HOURS:20240} personally caring for this critically ill patient on the unit/floor. I performed the following services: {CRITICALCARESERVICES:30350}. *(critical care services include choice of any/all of the following: direct hands-on care of the patient, reviewed test results, reviewed imaging studies, discussed the patient's care with other medical staff, discussed patient's care with family members or surrogate decision makers}*
- **.ATTESTPROCEDURE** - I was present for and supervised {PROCEDURE ATTESTATION:30351} *(procedure attestation includes choice of 1) the entire procedure or 2) key portions of the procedure, which were ***.)*

Teaching Physician Attestations- Timing/Location

I personally examined the patient and agree with the resident's note as written by Dr. Resident. Please see the resident's note for additional details.

Teaching Physician, MD
0130 4/12/2008

Computer Assisted Coding (CAC)

- EMRs
  - Coding prompts vs. auto-billed coding
- Ancillary
  - Low $ / high volume
  - Monitoring

What to watch for…

There should be no contradictions in the note!

(This means the providers MUST read ALL of the note before signing or attesting)

The chief complaint or reason for the encounter (usually documented by the nurse) should match the rest of the documentation!

Payer oversight has changed!

- **Template/Documentation issues**
- **Preformatted text**
- **Copying and pasting previous notes**

Pre-formatted text

What the provider intended…

*** {Patient name} is a {new/established} patient and presents today for a medical reevaluation

What was documented…

Mr. Jones is a new patient and presents today for a medical reevaluation.

Pre-formatted text

What the provider intended…

Patient has history of diabetes and {ask about blood sugar levels, diet, exercise, and medications}.

What was documented…

Patient has history of diabetes and is doing well {ask about blood sugar levels, diet, exercise, and medications}.

Know how the information got there….

- What information is actually reviewed for this Date of Service (DOS)?
- What information is "blown in" from the prior visits/patient history?
- What information is part of a pre-formatted template?
- Is the information all "medically necessary" for this DOS??????

Medicare payment requirements

Reported services must be:

- Performed in accordance with federal laws, regulations, and Medicare national payment rules
- Performed in accordance with Medicare coverage policies, national and local
- Performed by a qualified practitioner
- Performed for a qualified beneficiary
- Medically reasonable and necessary
- Coded correctly

Medical Necessity

- Appropriate in duration and frequency
- Provided in accordance with accepted standards of medical practice
- Performed by Qualified personnel
- Service meets but does not exceed patient's medical need

What's Medicare looking for in documentation?

- Documentation of the nature of the patient's presenting condition
- Documentation of the physician's response to the patient's complaint/condition
- Documentation supporting the Physician work

What we look at:

- Prior or subsequent notes
- “Cloned” notes
- Extensive documentation unrelated to the presenting problem
- Medical Decision Making consisting of only a problem list- no plan of care

Pitfalls of the EMR

- Personnel identity- Clear Policies and Procedures
  - Passwords
  - Audit trail
  - Electronic signatures

Pitfalls of the EMR

Physicians should not become slaves to system prompts

- Record should describe work performed at the visit, not a recapitulation of previously obtained information
- Enough history and physical to support diagnostic and therapeutic options but not too much irrelevant information
  - Adequate HPI to describe severity and acuity of patient's illness/condition
  - Thorough examination of "affected organ system" and related systems vs. endless "normal" and "negative"
- Cogent medical decision making vs. list of diagnoses derived from previous encounters

Pitfalls of EMR coding systems

- Conflicts in information
- Documentation by "exception"
- Understand internal system logic
  - 95 vs 97 EM guideline criteria
  - What medical decision making criteria are used?
  - How is medical necessity assessed?
  - Is medical necessity assessed?
  - Ability of the providers to make "on the fly" changes to the approved formats

QUESTIONS??????