Electronic Medical Records:
Auditing & Training Physicians

Georgette Gustin, CPC, CCS-P,CHC

PricewaterhouseCoopers

Faith Marie Hope, CPC, CCS-P, CHC

Nemours Children's Foundation

April 13, 2008

HCCA
HEALTH CARE
COMPLIANCE
ASSOCIATION

www.hcca-info.org | 888-580-8373

HCCA
2008
New Orleans
COMPLIANCE
INSTITUTE
April 13–16, 2008
www.compliance-institute.org
888-580-8373
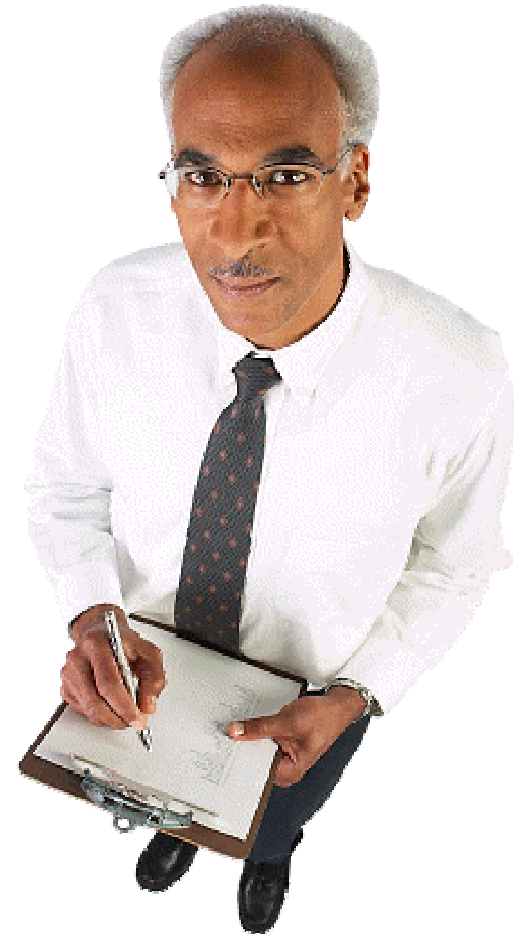
Today's Discussion

- Discuss the EMR through the eyes of the physician

- Provide practical tips for physician education

- Highlight the impact the EMR has on the coding and documentation auditing process

EMR: Physician Perspective

- Improves and streamlines documentation process
  - Preventive service reminders
    - Breast cancer screening, colorectal screening, immunizations and cholesterol screening
  - Clinical Guideline reminders
    - Diabetes care plans, etc.
    - Health maintenance guidelines
- Increase quality of care
- Enhance patient outcomes
- Patient safety
- Increase prescription accuracy and legibility
- Prevent drug allergy and drug interactions

EMR: Physician Perspective (cont'd)

- Improved coordination of care across care givers and specialties
- Improves operational efficiency
- Reduces and eliminate transcription costs
- Improves data quality – pay for performance
- Improves research
- Provides opportunities for data mining
- Receive CMS bonus for e-prescribing in PQRI
- Impacts productivity until proficient
- Reduces malpractice premiums
- Creates progress notes that look the same
- Concerns with practicing cook-book medicine

'**Excellence in medical documentation reflects and creates excellence in medical care. At its best, the medical record forms a clear and complete plan that legitimately communicates pertinent information, credits competent care, and forms a tight defense against allegations of malpractice by aligning patient and provider expectations.**'

Peter G. Teichman, MD, MPA
Documenting Tips for Reducing Medical
Malpractice Risk, FPM, March 2000

HCCA
HEALTH CARE
COMPLIANCE
ASSOCIATION

ICU EMR Study on Billing and Compliance

- Study Performed by Benjamin A. Kohl M.D., University of Pennsylvania, Philadelphia, PA, October 24, 2006

- Purpose of study is to determine what effect instituting an ICU specific EMR in an Academic Medical Center has on capturing billing events

  - Prior to EMR the billable encounters were abstracted by certified coders. During the study period there was no change in the attending coverage or coding staff

- Retrospective analysis of billable encounters prior /after EMR initiated

HCCA
HEALTH CARE
COMPLIANCE
ASSOCIATION

ICU EMR Study on Billing and Compliance (cont'd)

- The total # of billable events captured increased after the EMR was introduced

- The documentation supported critical care code billing in 55% of the encounters prior to initiation of the ICU EMR and 77% afterwards

- Conclusion: Implementing an EMR in an Academic Medical Center surgical ICU significantly increased the capture of billable critical care services CPT code 99291

Billing & Compliance

- What some people believe:
  - Improved compliance with Evaluation & Management (E&M) services
  - Reduction in billhold through more efficient coding and claims submission

- What others are finding:
  - Significant preponderance of higher level E&M codes
  - Progress notes which are much longer and difficult to follow
  - Information is being carried forward from past encounters that may not be pertinent to the reason for the visit
  - Difficult for coder/auditor to determine who performed which portion of the service
  - Concerns with copy/paste features

How are Payors Responding to the EMR

- Encouraging physicians to adopt EMR by paying a bonus in the P4P program
- A few years back Anthem BCBS of Ohio was cutting reimbursement rates as it found a 25% jump in the number of level-4 E&M codes submitted
  - No evidence of fraudulent coding was found
  - Identified the majority of physicians submitting higher levels were using EMR
- Instituted a "blend" rate for level 3 codes were Increased and level 4 coders dropped
- 75% of physicians expected to see no change, or a small increase in reimbursement
- 25% expected to see less reimbursement

:Source: amednews.com "Higher coding spurs plan to "blend" pay rates". Bob Cook, Dec 26, 2005

Educating Physicians on EMR

- Getting physicians up to speed on the many functionalities within an EMR is challenging due to:
  - Competing initiatives
    - Physician clinic schedules
    - In-boxes & messaging
    - Order Entry
    - Pharmacy
    - E-prescribing
  - Training impacts productivity
    - Reduce patient workload
  - Changes in day-to-day workflows
  - Lack of dedicated time for training

HCCA
HEALTH CARE
COMPLIANCE
ASSOCIATION

Educating Physicians on EMR Documentation

- Common Pitfalls:
  - Providing the training to far in advance of the go-live
  - Not allowing adequate time to provide training
  - Providing insufficient training materials or job aides
  - Using the wrong type of instructional trainer
  - Not providing an opportunity for practice and feedback
  - Lack of sponsorship and commitment at all levels

Educating Physicians on EMR Documentation

- **Best practices:**
  - Integrating the application (functionality) training with (concept) on coding and documentation rules
  - Incorporating case examples and hands-on practice with the system
  - Giving them access to the training environment for practice prior to go-live
  - Identifying physician sponsors or champions who are willing to assist with development or delivery of educational material

Draft Anti-Fraud Standards

- "There is a requirement for E&M coding, the system may inform physicians when their codes don't match their documentation. Can't tell physicians to add documentation"

- "It is appropriate for EHRs to calculate an E&M code from the encounter data which has been entered and to indicate the basis for that calculation".

- "However, it is not appropriate to suggest to the provider that certain additional data, if entered, would increase the level of the E&M code"

Documentation Challenges: The EMR

- Pitfalls:
  - Software that drives the record to show services that were not provided or necessary
  - Defaulted settings for automatic coding
  - Patient profiles look the same
  - Carrying past history forward (e.g., chief complaints and medical history) that unless over-rided will calculate systems and reviews that were not done leading to up-coding to a level that does not in any way reflect the circumstances of why the patient was being seen

Source: NHIC Medicare Bulletin, September 2006, page 100

Carrier EMR Guidance

- The clinical picture drives the amount of information; the amount of information does not drive the level of CPT code billed

- Filling out the entire form does not justify a higher level code

- The medical record must be individualized for each separate visit

- The presenting medical condition, the amount of work actually performed and the complexity of the medical decision making that determines the code

Source: NHIC Medicare Bulletin, September 2006, page 100

Carrier EMR Reminders

- Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code

- The volume of documentation should not be the primary influence upon which a specific level of service is billed

- Be cautious of an automatic tally of redundant or unnecessary bullet points

Source: NHIC Medicare Bulletin, September 2006, page 100
Medicare Claims Processing Manual, Chapter 12, Physician Services, Section 30.6

Medical Necessity

- Documentation should always be date and patient specific

- 42 CFR 482.24 (c)

- Providers must maintain records that contain sufficient documentation to justify diagnoses, admissions, treatments performed and continued care.

- Section 1862(a)(1)(A) of the Act states that no payment shall be made for any services which "..are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."

- Demonstrated by relationship of procedure codes and diagnosis codes supporting each other

HCCA
HEALTH CARE
COMPLIANCE
ASSOCIATION

www.hcca-info.org | 888-580-8373

CMS Teaching Physician (TP) Regulations

- Documentation may be dictated and typed or handwritten, or computer-generated and typed or handwritten

- Documentation must be dated and include a legible signature or identify:.

  - 42 CFR, 425.72 (b) documentation must identify at a minimum the:

    - service furnished

    - participation of the TP in providing the service

    - TP's physical presence

  - With an EMR it is acceptable for the TP to use a 'macro' as the required personal documentation **if** the TP adds it personally in a secured (password-protected) system

Source: CMS Manual System, Pub 100-4 Medicare Claims Processing, Transmittal 811, Change Request 3928, January 13, 2006

CMS Teaching Physician (TP) Regulations (cont'd)

- In addition to the TP's macro, the resident or TP must provide customized information that is sufficient to support a medical necessity determination

- The EMR note must sufficiently describe the specific services furnished to the specific patient on the specific date

- It is insufficient documentation if both the resident and the TP use macros only:
  - Physically present TP must be located in the same room as the patient (or partitioned/curtained area, if the room is subdivided to accommodate multiple patients) and/or perform a face-to-face service

Source: CMS Manual System, Pub 100-4 Medicare Claims Processing, Transmittal 811, Change Request 3928, January 13, 2006

About Nemours

- One of the Nation's largest children's health system
  - Alfred I. DuPont Hospital for Children, Wilmington, DE
  - Nemours Children's Hospital, Orlando, FL opening in 2011

- Nemours Children's Specialty Clinics
  - Delaware   11 clinics
  - Pennsylvania   6 clinics
  - New Jersey   2 clinics
  - Florida   8 clinics
    - Jacksonville
    - Orlando
    - Pensacola

- Employs approximately 1000 providers

Nemours Internal Auditing

- Seven coding compliance auditors
  - Certified professionals; AAPC and AHIMA
- Utilizes MD Audit® software
  - 1997 Evaluation & Management Guidelines
  - Concurrent medical record reviews
  - 10 records per provider
- Outpatient EMR installed in 2004
  - Coding Compliance was not involved in implementation process
- Inpatient EMR currently being installed with a Feb 09 projected live date
  - Coding Compliance actively involved this time around!

Nemours Provider Coding Audits

- Examples of some <u>Outpatient</u> EMR issues identified during the audit process

  - Is the internal order for a consult or transfer of care?
  - New versus established E&M category
  - APN/physician authentication
  - Templates and smart text
  - E&M calculator

Consultations

- Medical record review identified documentation issues
- After speaking with our providers, it was determined that the EMR did not offer a choice to indicate a consult vs. referral
- Worked with our Clinical Informatics team to change order
  - Order name changed to 'CONSULT/REFERRAL TO"
  - Prompted to choose either consultation or referral from list and asked to enter reason for the order
  - Consultation (request for opinion/advice): enter reason for consult
  - Referral (transfer of care): enter reason for referral
- Coding Compliance sent out communication to all providers which reviewed the consult vs. referral guidelines

New/Established Patient Category

- Upon medical record review for one specific department, the auditor noted that all patient encounters were billed as established when the sample documentation reflected both new and established patient categories

- Met with the department to discuss audit findings.

- It was discovered that this dept's EMR calculator was set to "established"patient status

APN/Physician Smart Phrases

- Upon medical record review, coding compliance discovered issues with the "incident to" smart text;

- Recommended Smart Phrase for an established pt:
  - "this services was provided incident to the care of Dr. xxx who was present in the clinic during the visit"

- Smart Phrase for established pt with new problem:
  - "Dr. xxx reviewed the history, examined the patient and established the diagnosis & treatment plan for this patient"

Audit Trail Report

- For some encounters, it may not be apparent to the auditor as to when each provider delivered their service

- Use of the EMR audit trail report can assist in making this determination

- Information typically recorded:
  - Provider name
  - Service rendered
  - Date
  - Time stamp

Sample Audit Trail Report

- **User Access Log   Module   Actions**
  Timestamp

- Fine, Lawrence   Encounter   View
  Mon Jan 7, 2008 11:06 AM

- Howard, Moe   Chief Complaint   View
  Mon Jan 7, 2008 11:14 AM

- Fine, Jerome   Chief Complaint   Accept
  Mon Jan 7, 2008 11:32 AM

- Marx, Julius   Vitals Section   View
  Mon Jan 7, 2008 11:38 AM

- Marx, Julius   LOS Activity   Accept
  Mon Jan 7, 2008 12:22 PM

EMR Templates

- **History**
  - Be sure that all elements of the history are supported by the template
  - Identify date when history from previous encounter is carried over
  - Hard to quantify history elements when provider documents free-form

- **Exam**
  - Does it contain the correct number of elements for constitutional (i.e. temp, BP, pulse)?
  - Does a single specialty exam created specifically by the physicians support E&M guidelines?
    - Correct number of bullets for a comprehensive exam

E&M Level of Service Calculator

- Can recommend codes but should not prompt users on what additional items need to be added for a higher E&M code level

- Nemours EMR model selects category but not level of E&M service
  - History = moderate
  - Exam = comprehensive
  - MDM = moderate

Avoiding EMR Automatic Pathways

- Check your software's default settings and remember to override them when they don't apply to a particular patient or service

- Don't be afraid to use templates but be sure to individualize for each patient

  - Do they represent all "levels" of E&M services?

- Modify or delete template language when it does not apply

- Be diligent in your training efforts

- Don't let your EMR select codes for you

Important Points and Questions....

- Review your EMR training material to ensure that it contains sufficient & correct coding documentation information

- Attend a physician EMR class
  - Level of service
  - Follow up visits
  - Level of service analyzer
  - Closing encounters

- Does the medical record provide documentation that is only relevant to the patient on a particular DOS?

Important Points and Questions..

- When developing templates, be sure to keep medical necessity in mind (is the template prompting more documentation than is required or performed

- Always ask…can the electronic medical record stand <u>alone</u> to support the services rendered & billed?

- Monitor E&M bell curves pre and post implementation

- Maintain Data Quality & Integrity of the Medical Record

Questions/Answers

Georgette Gustin, CPC, CCS-P, CHC
PricewaterhouseCoopers
Georgette.gustin@us.pwc.com
(317) 860-2131

Faith Marie Hope, CPC, CCS-P, CHC
Nemours Children's Foundation
fhope@NEMOURS.ORG
(302) 651-4141