P5 EMR Challenges, Risk and Solutions

HCCA Compliance Institute
April 18, 2010

Speakers

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Agenda

- Basic Definitions
- Identify where risk is associated with specific functions in an electronic medical record
  - AHIMA Areas of Concern
  - Other Risk areas
  - ARRA Meaningful Use
  - Examples
- Transitioning coders to a new paradigm
- Present methods to audit and monitor the controls of the electronic record

EMR: More than just a SOAP note

1. Patient Registration (membership files)
2. Scheduling patient visits
3. Provider Scheduling Templates
   - Different visit types on busy/light days
4. Office Visit Note Types – Routine OV, Procedure Visit, Consults*
5. Charge Entry/Coding Work Queues
   - Example: edits stop modifier eligible claims
6. Billing Work Queues
7. Collection Software
8. Documentation Management (scanning software)
9. Voice Recognition and more…
Glossary - Definitions

Alphabet Soup

**EMR:** Electronic Medical Record –
- Created, gathered, managed and consulted by physicians and staff in one healthcare organization

**EHR:** Electronic Health Record – EMR plus:
- Conforms to nationally recognized interoperability standards
- Created, gathered, etc. across more than one healthcare organization

**PHR:** Personal Health Record –
- An electronic, universally available, lifelong resource of health information needed by individuals to make health decisions,
- Individuals own and manage the information listed that comes from both healthcare providers and the individual
EMR: Definitions – Alphabet Soup

- **Structured Data:** Codified text with embedded codes or information that allows accurate retrieval of information – a statistician’s dream, a coder’s 784.0

- **Free Text:** Typing or dictation that is in the clinician’s own words – most information is not codified so not reportable

“Smart Tools”

(Shortcuts for better documentation)

- **Smart Sets** - Templates for complete documentation of encounter and related procedures or tests
  - Allow documentation and coding for entire problem

- **Smart Text** - Problem specific documentation
  - More specific problem/guidance

- **Smart Phrases: “dot” phrases** - Common pretexted phrases
  - .bmi: (calculates and pulls in last body mass index).
  - .nexheart: (pulls in negative exam for CV system)
  - .negneuro: (pulls in negative neuro ROS questions)
AHIMA - Areas of Concern

- **Authorship integrity risk:** Borrowing record entries from another source or author and representing or displaying past as current documentation, and sometimes misrepresenting or inflating the nature and intensity of services provided.

- **Auditing integrity risk:** Inadequate auditing functions that make it impossible to detect when an entry was modified or borrowed from another source and misrepresented as an original entry by an authorized user.

Guidelines for EHR Documentation to Prevent Fraud
AHIMA - Areas of Concern

- **Documentation integrity risk:** Automated insertion of clinical data and visit documentation, using templates or similar tools with predetermined documentation components with uncontrolled and uncertain clinical relevance

- **Patient identification and demographic data risks:** Automated demographic or registration entries generating incorrect patient identification, leading to patient safety and quality of care issues, as well as enabling fraudulent activity involving patient identity theft or providing unjustified care for profit

Authorship Integrity

- Inaccurate representation of authorship of documentation
- Duplication of inapplicable information
- Incorporation of misleading or 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 continued…

- Inability to accurately determine services and findings specific to a patient’s encounter
- Inaccurate, automated code generation associated with documentation
- Lack of monitoring open patient encounters
- Cut, copy and paste functionality
- Incident to

Copy and Paste

- It is not all bad (but most of it is).
- Two varieties:
  - Word (Ctrl C)
  - Computer generated
- Concern:
  - Copying and pasting is not noncompliant. It is how the information is used or “counted.”
  - For example, according to Trailblazer's September 30, 2002, bulletin, Medicare is also concerned that the provider's computerized documentation program defaults to a more extensive history and physical examination than is typically medically necessary to perform, and does not differentiate new findings and changes in a patient's condition.”
Copy and Paste: Options to Minimize Risk

- **Option 1:** Eliminate all (then leave town).
- **Option 2:** Allow all Copy and Paste, but audit and count inappropriate use as an error.
- **Option 3:** Hybrid of 1+2:
  - Eliminate “Copy Previous Note Forward” and other high-risk duplication.
  - Leave traditional Word copy and paste alone.
  - Count as an error any inappropriate use of the copy and paste functionality (in audits and feedback).

Exploding Notes: Explosive Topic

- Check a box, get a sentence. The same one every time.
- Profoundly troubling
- Exploding notes & Natural Language Processing that reads and assigns code to the automated information
  - Does not sort out Medically Necessary information
  - EHR Assigns code on word quantity not PERTINENCE

“Things can get even more perilous with the use of exploding notes, the compliance officer says. Exploding notes or exploding macros means a simple check off of ‘normal’ or ‘negative’ prompts the documentation of a complete organ system exam.”
Exploding Notes: How to Minimize Risk

**Recommendation:** Do not implement non-editable canned statements linked to check boxes.

- Most physicians do not enjoy coding or documentation. They embrace shortcuts, not considering compliance risks.

- **Your role:**
  - Point out these competing tensions: short cuts/compliance
  - Turn up the light, not the heat!

- **Mitigate the risk if you do implement note writer functionality**
  - Must have the capability to be edited
  - Phrases should be in each provider’s own words

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Auditing Integrity

- Authentication and amendment/correction issues
- Addition of more text to the same entry
- Auto authentication
- Lack of monitoring activity logs
# Sample Audit Trail Report

<table>
<thead>
<tr>
<th>User Access</th>
<th>Module</th>
<th>Actions</th>
<th>Time stamp</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fine, Lawrence</td>
<td>Encounter</td>
<td>View</td>
<td>Mon Jan 7, 2008 11:06 AM</td>
</tr>
<tr>
<td>Howard, Moe</td>
<td>Chief Complaint</td>
<td>View</td>
<td>Mon Jan 7, 2008 11:14 AM</td>
</tr>
<tr>
<td>Fine, Jerome</td>
<td>Chief Complaint</td>
<td>Accept</td>
<td>Mon Jan 7, 2008 11:32 AM</td>
</tr>
<tr>
<td>Marx, Julius</td>
<td>Vitals Section</td>
<td>View</td>
<td>Mon Jan 7, 2008 11:38 AM</td>
</tr>
<tr>
<td>Marx, Julius</td>
<td>LOS Activity</td>
<td>Accept</td>
<td>Mon Jan 7, 2008 12:22 PM</td>
</tr>
</tbody>
</table>

# Documentation Integrity

- 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
- Problem list maintenance is inconsistent
Templates: A Necessary Evil

- Reminders for important “red flag” questions
- For example, strep throat template would have the prompts below:
  - Consistency and medical/legal liability coverage
- Despite the well-intended questions, all the visits look exactly the same.

Templates: Challenges

- Templates generate canned phrases, which makes them lose uniqueness
- Multiple consecutive canned statements causes a poor read that may misconstrue the intended meaning
- One-size-fits-all templates are incomplete, not comprehensive enough and only work for one problem
- Subjective observations go undocumented. AVA study saw increased errors with templates.
- Templates drive more unnecessary documentation. Many times they cannot be closed until all boxes are checked, which then drives higher E&M levels.
Templates: How to Minimize Risk

- Embed placeholders for free text
- Offer all code ranges for procedures and visits. Visits must allow all levels (not just the probable ones). All multiples of the procedures should also be offered.
- Make your job easier by embedding add-on codes and multiples of J-Codes so you do not have to add them on the back end.

Other Risk Areas

What to consider besides AHIMA Areas of Concern?
General

**Structured Data:**

- **Advantages:** enables stated values to be supported for specific variables so as to provide standard meaning for reporting purposes (all entries are reportable data)
- **Disadvantages:** Predetermined display names and consistently structured phrases appear the same in all charts; does not allow for descriptions in the clinicians own thoughts or style
  - The classic completely “canned text” note

General

- **Free Text:**
  - **Advantages:** Preserves the narrative component of the medical record. Each visit appears different because the clinician created it specifically for the individual patient.
  - **Disadvantages:** Typing and dictation must be done for each patient by a clinician who would rather be seeing patients than typing. This typing, dictating or filling out templates is very onerous
General

- Monitoring of coding by EMR is not done
- Assume EMR coding matches billing system
- Coding “assistance” via the EMR product itself (CPT & ICD)
- Coding in EMR is valid although based on pre-determined design

General

- Tracking of user’s changes, deletions or modification to a specific subsystem
- Lack of policies and procedures related to coding and documentation related to EHR
- Lack of EHR retention policies
Other Issues

- Medical necessity
  - Potential for overstatement of medical issues
  - "Clinical pathway" – followed or not
  - Masking of substandard care
- Addendums
- Modifiers
- Abbreviations

Other Issues

- Diagnostic code assignment
  - "Code also"
  - "Code first"
  - Shortcuts
- Multiple encounters being “available” for documentation
And more. . .

- CPT, HCPCS and ICD codes table maintenance
  - Version controls
  - Update process
  - Testing for effect of updates…information system and coding input into the process
- Audit trails
- Timeliness

ARRA - Meaningful Use

What are the risks?
ARRA: Qualifying for Incentives

“Meaningful Use” criteria must be met*
- Much debated and released 12/30/09
- Groups have 60 days to comment
- 25 requirements for providers
- 21 for hospitals
- Most do not directly impact coders
- Requirements include, CPOE, pharmacy, problem lists, allergies, demographics, billing functions, clinical decision support, HIPAA, information exchange and much more. (see appendix)

Make Meaningful Use Meaningful

Requirement: Computer Physician Order Entry (CPOE)
- 80% of all orders must be done via the computer
- Options for the display names of the orderable procedures
  - Use software’s display names
  - Make your own and manage the display name file
- Advantage of creating your own display names:
  - Embedded coding hints
  - Example: reminders for add on codes
  - Reminders for quantities of J Codes
  - Reminders to give size of lesion

*Definition as of 12/30/09
Make Meaningful Use Meaningful

**Requirement: Problem Lists: must be up to date**
- 80% of all patients seen must have Problem List entries
  - “None” is ok but it must be structured text
- The compliance issue with Problem Lists not up to date
  - Most EMR’s have a key stroke that loads the Problem List into the Progress Note
  - Discrepancies occur as the Problem List diagnosis is not consistent with free text documentation
  - Example: Pt is declared free from cancer in the text of the note but the “blown in” Problem List states: Breast Cancer.
    - This conflicting information requires a query

*Definition as of 12/30/09

Make Meaningful Use Meaningful

**Requirement: Clinical Decision Support**
- 5 significant CDS must be implemented
  - Example: Doctor orders a drug and gets a pop-up that the patient has concurrent Chronic Kidney Disease and the dose of the antibiotic should be decreased
- “Borrow” the technology for coding support
  - Instead of clinical help, the doctor gets coding help
  - Example: doctor types in “Stroke” for the diagnosis. A pop-up appears telling them they should not use this code unless this is an acute event. Hyperlinks in the pop-up direct them to late effect choices
  - Used for cancer/history of cancer as well

*Definition as of 12/30/09
Interview

What questions should you ask your information technology or EMR implementation team?

Authorship Integrity Questions

- Does the EHR system have the capability to attribute the entry, modification or deletion of information to a specific individual and/or subsystem?
- Does it have the capability to use a common date and time stamp across all components of the system?
- How does the EHR system check for duplication and conflicts?
- How does the organization track if a record or report has been altered?
- How does the EHR system provide access control functions?
- Does the organization have policies and procedures that define the management of user authentication?
If this section is referring to "Vendor" interview questions, then you should call the section "Vendor Interview Questions."

This is actually to internal staff

Lori Laubach, 1/21/2010
Auditing Integrity Questions

- Does the EHR system establish a process for logging all activity on the EHR?
- How long after an entry can the documentation be amended or corrected?
- Does the EHR system preserve data produced in response to a specific request, or can it be recreated reliability?
- How does the audit record maintain the first entry to a medical record?
- Is the record amenable by the original creator or another staff?
- Does the organization have policies that define retention periods and procedures for log records, and know if a record is finalized or completed on the system?

Documentation Integrity Questions

- Does the organization have policies and procedures that specify:
  - Documentation requirements in the EHR
  - What medical information can be copied from one record to another
  - What information can be copied forward within a patient’s medical record from one encounter to the next
  - Definitions for how changes, i.e. corrections and amendments are made to all records
  - Assignment of responsibility for auditing of log entries and reported exceptions.
- Is editing capability restricted to open versus closed records?
Patient ID & Demographic Accuracy Questions

- What processes are in place to ensure that the availability of system functionality would not lead to clinical issues not being updated to reflect a clear change in patient’s condition?
  - How is this controlled?
  - How is this monitored?

- What processes are in place to ensure that the availability of system functionality would not lead to or prevent the propagation of misinformation or error?

Coding Paradigm Shift

With an EMR – how does the coding world change?
Coding Survey

- Majority used the coding queue of the EMR to hold claims based on risk areas
- Coders would review these claims
- Claim Scrubber software in addition to EMR
- In some entities, the coding auditors were not separated from coders working denials

Coding Survey

- One to two minimal audits done by provider
- Randomly pull prospective sample from schedule and hold in coding audit queue
- Report to providers
- Trending done of utilization, not of coding audit results
EMR Coder Role: Primarily Front End

- Office Visit – MD documents in EMR
- Codes are embedded in EMR display names – no fee ticket
- Embedded codes autoadjudicate – 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/addendum/query

**Coders Role:** MD becomes “de facto” coder so proactive education crucial as most claims untouched by coder

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Rescue/Recovery Role in Paper World

- **RESCUE CODING**
  - Automated and Human
  - Sanitizes Claims
  - Coding/Billing Rules
  - Last Chance Intervention

- **INSURANCE**

- **RECOVERY CODING**
  - Researches Denial
  - Repairs Claim
  - Queries Physician
  - Supplies Documentation
Kaiser Permanente’s Case Study

- EMR forced docs to “code” as codes were embedded in diagnosis/procedures names
- Doctors as “de facto” coders = scary thought
- 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

In addition to EMR, as an HMO, we didn’t code

- 80% of our growth comes from insurance products that didn’t exist 3 years ago – all coding dependent
- We needed our docs to choose correct procedure display names and corresponding diagnoses to meet medical necessity

- Our baseline accuracy was poor:
  - Diagnosis Accuracy = 75%
  - Level of Service (LOS) = 52%
  - Procedure = 82%
KP’s Case Study: Our Solution

- Clinic based department specific coders doing on-site auditing and feedback
- Monthly 20 minute 1:1 educational feedback session for each of 1,000 providers in the region
- Find “extroverted librarian” coders to be the face of Coding embedded in the clinical dept
- Staff to a 1:40 coder to clinician ratio
- 10 Charts per month audited

KP’s Case Study: Our Results

1. Just Celebrated 95% accuracy in diagnosis, E&M and procedure coding for Colorado region
2. 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
3. Inpatient Documentation Improvement started
4. Disease Definition/Specificity Education
5. Higher coder job satisfaction!!!
KP’s Case Study: Educator Qualities

Shifting from rescue/recovery to audit/educator
- Difficult transition as always used to rescuing
- Now need to teach only to level MD is responsible for and trust the process
- Rescue coding still takes place so all rules are not taught to physicians
  - All Trailblazer claims are stopped in one queue
  - It’s easier to teach 5 work queue coders Trailblazer’s changing rules than teach 1,000 MD’s

KP’s Case Study: Educator Qualities

- “Extroverted Librarian” – find that outgoing coder
  - Many coders prefer to code and leave the doctors to be doctors and coders to be coders
- Professionalism – critical to blend into clinic
  - Dress, speech, attitude, demeanor, coding expert
- EMR Expertise
  - Must know coding portion of EMR the best
- Relationships
  - Change is best done with you rather than to you
KP’s Case Study: Educator Duties

1. Audit and give feedback/education on 10 charts for roughly 40 providers a month
   - This is about 800 feedback sessions a month in the region
2. Be available for addition ad hoc education requests
3. Coding Spotlight
   - 5-10 minutes of the monthly departmental provider mtg
   - Content: changes to ICD/CPT or common errors in the dept
   - Tips/Tricks in EMR to make coding easier
4. Stay current on clinical department coding changes
5. Learn and use coding audit software
   - Pulls statistically random cases; records audit findings

Sample Work Plans

How do I audit it now?
Audit Procedures – Authorship Integrity

- User access
  - Rights testing
  - Role assignment and security point consistency
- Determine the capability of user log in/passwords used simultaneously and different workstations
  - Review user access listing – 1 person – multiple login/passwords?
  - Medical students

Audit Procedures – Auditing Integrity

- Determine EHR editing capability
  - Open versus closed records
  - Create test patient
  - Examine audit logs for audit trail
- EHR capability to use common date/time stamp across all components—test to determine if this can be manipulated in any way either in Epic or in the background.
  - Select one encounter and edit or add information
  - Test date and time stamp
Audit Procedures – Documentation Integrity

What is the volume and timing to closure of typical encounter documentation?

- Obtain and review Patient Billing reports to identify volumes, aging, and types of open encounters
- Select a sample of encounters which are “closed” and have no progress note documentation and determine the amount of time from open to closed timeframe
- Review the EMR and identify if progress notes were written in the correct section

Auditing Specific EMR Functionality

What other items should I consider?
Cut & Paste – Copy & Paste

- Audit Difficulty: Identifying if this function was used
- Documentation Integrity Risk:
  - Bring forth information which is not specific to the patient
  - Fail to edit information that is not applicable to the subsequent encounter
- Utilized software originally designed to detect plagiarism at universities
- Using encounter data, compared the following EHR
  - Same provider, same primary diagnosis
  - All visits for one day for a provider

AHIMA article: [http://library.ahima.org/xpedio/groups/public/documents/ahima/bok3_005520.hcsp](http://library.ahima.org/xpedio/groups/public/documents/ahima/bok3_005520.hcsp)

Templates

- Identify sample of patient encounters where a template was selected for the encounter documentation. (frequent template users – GI, cardiology, urology, respiratory, and primary care)
- Review EMR documentation to ensure that any default information was verified or updated (patient name, symptoms, medication, etc.)
- Review the EMR audit logs to ensure that the defaulted information was edited (inquire how this should look prior to examination)
Make Me the Author

- Audit Difficulty: Identifying when this function was used
- Test EMR system controls by creating a patient encounter using another provider user ID (or RN) and create documentation
- Review EHR documentation & audit logs (dark side) to ensure that test documentation is attributable to the correct provider
- Turn off / remove this functionality if the EHR does not have the capability to attribute an entry, modification or deletion to a specific individual

Auditing EMR - Solutions

- Where to start – a daunting task
  - Compliance violations built in and growing
  - Over extended staff can’t take on another paper process
- Root Cause Analysis
  - Capture and Compile data
  - Develop corrective education process
  - Monitor and report progress
- Plan and Execute Follow-up audits
  - Automate the process
  - Track results
Auditing EMR - Solutions

<table>
<thead>
<tr>
<th>Audit Rules</th>
<th>Possible Violations</th>
<th>Create</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the note closed?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was the note closed in 48 hours?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Were progress notes removed?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does EMR billing suggestion match billing system?</td>
<td></td>
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Questions?

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