Auditing the Electronic Medical Record.

The good….the bad….the ugly

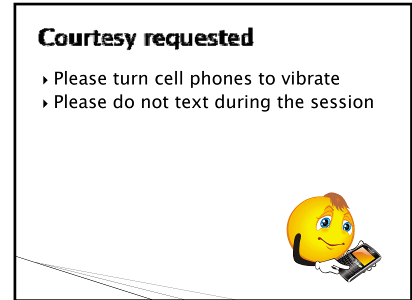
Judy B Breuker
CPC, CPMA, CCS-P, CHCA, PCS, CEMC, CHC, CHAP

Disclaimer

- This course was current at the time it was written.
- Every reasonable effort has been made to assure the accuracy of the information.
- Proper coding may require analysis of statutes, regulations or carrier policies and as a result, the proper code result may vary from one payer to another.
- This program is not intended to be legal advice and your attendance should not be construed as a legal opinion of the presenter.
- Resource used for presentation: Electronic Medical Records: Auditing Challenges and Associated Risks AHLA/HCCA Fraud & Compliance Forum authored by Faith Marie Hope http://www.healthlawyers.org/Events/Programs/Materials/Documents/FC09/hope_slides.pdf

Courtesy requested

- Please turn cell phones to vibrate
- Please do not text during the session



Agenda

- Back to basics
  - Medical Necessity
  - Nature of the presenting problem
- Why audit
- EMR documentation challenges
  - Cloned documentation
  - Diagnosis coding issues

Medical Necessity & E/M per CMS

- *Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted.* ***The volume of documentation should not be the primary influence upon which a specific level of service is billed.*** *Documentation should support the level of service reported.*

The Nature of the Presenting Problem

- ***Minimal:*** A problem that may not require the presence of the physician, but service is provided under the physician's supervision. (99211)
- ***Self-limited or minor:*** A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status OR has a good prognosis with management/compliance. (99201 / 99212)

The Nature of the Presenting Problem

- ***Low severity:*** A problem where the risk of morbidity without treatment is low; there is little to no risk of mortality without treatment; full recovery without functional impairment is expected. (99202/99213)

The Nature of the Presenting Problem (99204/99205/99214/99215)

- ***Moderate severity:*** A problem where the risk of morbidity without treatment is moderate; there is moderate risk of mortality without treatment; uncertain prognosis OR increased probability of prolonged functional impairment.
- ***High severity:*** A problem where the risk of morbidity without treatment is high to extreme; there is a moderate to high risk of mortality without treatment OR high probability of severe, prolonged functional impairment.

99214 – BE AWARE!

- http://www.wpsmedicare.com/part_b/business/2010_0315_otherprobe.shtml
- For 2010 WPS – *widespread service-specific prepayment probes will be conducted on Current Procedural Terminology (CPT)® Code 99214*
- Providers must submit **ALL** the documentation that is necessary to support the **medical necessity** for each billed service and to **substantiate the appropriate use of each billed procedure code**.

CERT ERROR REPORT

- http://wpsmedicare.com/part_b/business/1109_cert_errors.pdf

Auditing EMR Challenges

Integrity of the record

- What controls are in place around access and the ability to modify
- Who documented what?
- Signatures/authentication
- Cut/paste/copy features
- Cloning
- Macro's

The Dangers of Copy and Paste

- Documentation shortcuts are tempting for busy clinicians. The innovation of the EHR, which allows for easier movement of information, has made it easier to reuse previous documentation with a single click. But the practice can lead to serious consequences for both patient care and reimbursement, some auditors say.

Shortcuts in Electronic Records Pose Risk by Chris Dimick

The Dangers of Copy and Paste

- Carrying forward information without careful review can cause contradictions in a patient's chief complaint documentation or history of present illness.

Shortcuts in Electronic Records Pose Risk by Chris Dimick

The Dangers of Copy and Paste

- Unless the clinician reads that information word for word, line for line, and reevaluates it, they may inadvertently be copying forward information that is not accurate." Past complaints or symptoms in current documentation can lead to a host of errors, including misinformed treatment.

Shortcuts in Electronic Records Pose Risk by Chris Dimick

The Dangers of Copy and Paste

- Many times, physicians have clearly cut and pasted large blocks of text, or even complete notes, from other physicians; we have seen portions of our own notes inserted verbatim into another doctor's note. This is, in essence, a form of clinical plagiarism with potentially deleterious consequences for the patient."
  - April 2008 issue of the New England Journal of Medicine

Shortcuts in Electronic Records Pose Risk by Chris Dimick

Copy Risks

- Using the copy functionality in an EHR system poses risk to documentation integrity, including:
  - Inaccurate or outdated information that may adversely impact patient care
  - Inability to identify authors or what they thought
  - Inability to identify when the documentation was created
  - Inability to accurately support or defend E/M codes for professional or technical billing notes
  - Propagation of false information
  - Internally inconsistent progress notes
  - Unnecessarily lengthy progress notes

Auditing Copy and Paste www.ahima.org

Sample Copy Audit Policy

- PURPOSE: The purpose of the health record is to provide a basis for planning patient care and for the continuity of such care. Each record should provide documentary evidence of the patient's medical evaluation, treatment, and change in condition as appropriate. The purpose of this policy is to provide guidance on the audits required in conjunction with the copy functionality within the EHR. For the purpose of this policy, copy shall be understood to include cut and paste, copy forward, cloning, and any other movement of documentation from one part of the record to another.

Auditing Copy and Paste www.ahima.org

Sample Copy Audit Policy

- **POLICY**: In order to protect the integrity of the health information record and to provide quality patient care, copy functionality within the EHR should be used in conjunction with all applicable state and federal regulations. Noncompliant use of copy functionalities is considered a sanction offense in accordance with the organizational policies.

Sample Copy Audit Policy

- **PROCEDURE:**
- *[Insert responsible party; e.g., HIM Department]:*
- Determines how and when audits will be conducted
- Determines who will perform these ongoing concurrent audits
- Establishes frequency for performing the audit
- Establishes time period covered by the audit
- Identifies how the sample size is determined
- Identifies a description of the outcome indicators
- Determines how copy functionalities within the record are identified
- Designs a corrective action plan based on findings

Auditing Copy and Paste
www.ahima.org

Copy Functionality Toolkit

- http://www.ahima.org/infocenter/documents/copy_functionality_toolkit.pdf

Code choice

- Who is choosing the code?
  - System?
    - Just bullet points
  - Physician?
    - Level of training or desire to learn
  - Coder?
    - Level of training or desire to learn

New / Established

- Many times the EMR coding calculator is defaulted to “established” and providers fail to change the category

Modifiers

- Who is attaching the modifier?
  - Modifier -25
  - http://oig.hhs.gov/oei/reports/oei-07-03-00470.pdf
  - Is the record being reviewed prior to adding modifier -25?

Units

- Inaccurate or missing units
  - Medications
    - 40 mg of Kenalog turns into 4 units
- Documentation of time for time-based codes
    - PT/OT services
    - 15 minutes = 1 unit (not 15)

“Incident-To” Services

- Identifying the plan of care
- Have the supervision requirements been met?
- Caution use of “make me the author” feature
    - For example, a medical assistant may complete a history and physical on a patient in totality. The supervising physician may subsequently log in to the record, evaluate only proof of positives and negatives, and electronically sign the documentation in such a way that it overwrites the presence of the medical assistant.

CMS Teaching Physician Regulations

- It is acceptable to use a teaching physician macro if the TP adds it personally in a secured and password protected system
- The TP must provide the required customized information to support his/her involvement in the encounter

EMR Templates

- History
- *The extent of history of present illness, review of systems and past, family and/or social history that is obtained and documented is dependent upon clinical judgement and the* ***nature of the presenting problem(s).***

EMR Template

- *The extent of examinations performed and documented is dependent upon clinical judgement and* ***the nature of the presenting problem(s).***
- Audits of EMR records have revealed exams that were nearly identical on subsequent visits, even when there was a change in diagnosis

EMR Template

- Free text is often not picked up by software therefore E/M coding may be inaccurate
- Many providers rely too heavily on the templates and fail to modify or delete the template language when it does not apply

Procedure Templates

- Procedure explained to the patient?
- Risks / benefits
- Indications for the procedure
- Anatomic location
- Local Anesthesia
- Instruments used
- Procedure performed
- Dressings
- Patient condition

EMR on Payer Radar

- How much was templated?
- Copying and pasting from previous visit
- Does the chief complaint and medical decision making support the level of service billed

Cloning

- Cigna Goverment Services:
  - 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 overpayments made.

Cloning

- First Coast Service Options “Requirements for the Payment of Medicare Claims”
  - *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*

Planning the EMR Audit

- Start by reviewing 10 notes per provider
  - 10 on one date of service or 5 patients with 2 services relatively close
- Determine if education is needed
- Internal auditing 3 times a year, external by a certified auditor once a year

Planning the EMR Audit

- Determine Audit Scope
  - Avoid “scope creep”
  - E/M levels only?
  - Procedures?
  - Diagnosis coding?
  - Pre or post claim submission review?

Amendments, Corrections, and Deletions in the EHR

- http://www.ahima.org/infocenter/documents/AmendmentsCorrectionToolkit.pdf

Take Away Pearls

- Audit
  - Internal & External
- Attend EMR Training Sessions
- Identify who is responsible for maintaining and updating clinical content

DISCUSSION

Judy
judy@judybreuker.com