Balancing Compliance & Quality
Templates, Encounter Forms
& Electronic Medical Records.....

HCCA Physician
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Balancing Compliance & Quality
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Session Agenda & Objectives

- Discuss the impact that templates, encounter forms and computerized medical records have on compliance and quality of care
- Identify where, how, who, when and what types of compliance and quality concerns they can generate
- Review and discuss various case examples
- Discuss and share best practices
- Questions and Answers

Striving to Balance Compliance & Quality

- Pros and cons associated with using various types of forms
- Charge capture purposes
- Encounter Forms
- Clinical documentation
- Coding, Billing and Reimbursement
- Quality of care initiatives (Utilization Review, Case Mgmt, etc.)
- Continuity of care
- Patient safety
- Medical and Legal requirements and standards
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.
- Need to always keep Medical Necessity in mind when developing encounter forms, documentation templates or reviewing computerized medical record systems and capabilities.

Medicare Conditions of Participation

Section 482.24 Condition of participation: Medical record services.
- Legible and Complete
- Authenticated and dated promptly by the person
- Must be within 48 hours of admissions
- Quality of Care
- Continuity of appropriate treatment
- Orders & Reports
- Final diagnosis within 30 days following discharge
JCAHO Medical Record Requirements

- Standard IM.6.10
- Every hospital must have a complete and accurate medical record for every patient assessed or treated
- Made by authorized individuals
- Dated, signed, and author identified
- Hospital has policy defining when counter-signature necessary
- Standardized formats for all services

JCAHO Medical Record Requirements, (cont.)

- The following must be authenticated by: written signature, electronic signature, or computer key or rubber stamp
  - history and physical examination
  - operative report
  - consultations
  - discharge summary
- Contains information to identify patient, support diagnosis, justify care, document treatment and results, and show continuity.
JCAHO Medical Record Requirements, (cont.)

- Concise and complete discharge summary
- Hospital has policy ensuring timely entries
- Record complete within 30 days of discharge
- Hospital checks record delinquencies every three months
- Reviewed continually for presence, timeliness, legibility, completeness, etc.
- Retention time complies with applicable law and regulation

JCAHO Medical Record Requirements, (cont.)

- Originals not released unless mandated by law
- For emergency patients, must contain:
  - time and means of arrival
  - whether patient left against medical advice
  - final disposition, conditions, follow-up instructions
  - notation that copy is available for follow-up care provider
“Medicare audited 128,000 claims submitted by healthcare providers, as opposed to the 6,000 audited the year before. There are expected to be 170,000 audits this fiscal year.”

Mattera, Marianne D., “Price fixing; Memo From The Editor; Editorial” Medical Economics No. 4, Vol. 81; Pg. 9 February 20, 2004 Copyright 2004 Advanstar Communications, Inc.

“Measure, assess and, if appropriate, take action to improve the timeliness of reporting, and the timeliness of receipt by the responsible licensed caregiver, of critical test results and values.”

- One of JCAHO’s new 2005 hospital’s national patient safety goals, available at http://www.jcaho.org
Legal Concerns with Documentation Practices

- False Claims Act
- Anti-Kickback Statute

Civil False Claims Act

- Prohibits
  - filing or causing to be filed
  - “false or fraudulent” claims

- Intent
  - “Intent to defraud” not required
  - Filing claims with “reckless disregard” of their truth or falsity is sufficient for a claim to be brought

- Liability
  - 3X Damages
  - $5,000 - $10,000 per claim
Civil False Claims Act (cont.)

- **Qui Tam Provisions**
  - "Private attorney generals"
  - Can proceed even if Government declines
  - Can receive up to 30% of recovery
  - Over 4000 Qui Tam actions in 2000, collecting over $1,000,000,000 from hospitals

Anti-Kickback Law

- 42 U.S.C. § 1320A-7b(b) prohibits the payment of an "inducement" (anything of value) for the referral of Medicare and Medicaid business. This prohibits both the solicitation or receipt of the inducement, as well as the offer or payment. Felony - $25,000 fine per violation AND imprisonment for up to 5 years
- Civil penalties:
  - $50,000 per violation
  - 3X damages
- Possible False Claims Act liability
Documentation Templates

<table>
<thead>
<tr>
<th>Pros</th>
<th>Cons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Streamline documentation capture process for providers</td>
<td>Limit providers ability to free text information</td>
</tr>
<tr>
<td>Provide standardized information</td>
<td>May promote documenting more than what was rendered</td>
</tr>
<tr>
<td>Improve legibility</td>
<td>Can lead to “canned” or “cloned” documentation</td>
</tr>
<tr>
<td>Aid in continuity and quality of patient care</td>
<td>May be used inappropriately or misinterpreted by the user</td>
</tr>
<tr>
<td>Assist providers in recalling the documentation requirements</td>
<td>May promote non-compliant short-cuts</td>
</tr>
<tr>
<td>Easier to audit and provide feedback</td>
<td>May turn medical record progress notes into audit worksheets</td>
</tr>
</tbody>
</table>

Template Examples
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Chart Template
Office Progress Note # 1

Would this progress note template capture all levels of E/M Services?

Chart Template
Symptom/Condition Template # 2

Is this chart template date and patient specific?

Does this template support all levels of E/M services?
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Chart Template Example #3

Sample Progress Note – Sick Visit
Handwritten Documentation
Progress Note Example # 1

Progress Note & Combined Encounter Form Example
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Legibility and Documentation (cont.)

“Illegible documentation is of no value in verifying medical necessity or coding accuracy”.


Section 1833 (e), Title XVII of the Social Security Act (the Act) provides in part that:

“No such payment shall be made to any provider of services or other person under this part unless there has been furnished such information as may be necessary in order to determine the amounts due such provider or other person under this part for the period with respect to which the amounts are being paid or for any prior period”.

Encounter Form Examples
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Sample Outpatient Encounter
Form # 1

Assists physicians with recalling E/M requirements

Sample Outpatient Encounter
Form # 2

Provides a mechanism to sequence up to 4 diagnosis codes
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Sample Outpatient Encounter Form # 3

Sample Inpatient Encounter Form #1

Includes ABN Statement with Incomplete language

Assists with diagnosis coding sequencing

Provides a method to capture diagnosis codes on daily basis
Inpatient Encounter Form Example

Provides a method to capture inpatient hospital admits, daily care, consults, etc.

Encounter Form Action Steps

- Encounter forms should contain only current CPT-4, HCPCS Level II and ICD-9-CM codes
- Descriptions that correspond to the codes should be accurate and not misleading
- Include all levels of Evaluation and Management (E/M) Services for each applicable category (e.g., consult)
- Include revision dates and form names/numbers on each form
- Review frequency data (apply the 80/20 principle)
Encounter Form Action Steps (cont.)

- Allow physician free text space
- Establish a mechanism to link and sequence diagnosis code to CPT codes
- Include applicable modifiers
- Provide education on the use of the form
- Monitor the completeness of the form
- Provide feedback
- Review and update annually

Electronic Medical Records
Sample EMR Template

Computerized Documentation
Carrier Probe Review Findings

- One of the probe reviews found several physicians whose office records indicated they use a computerized documentation program that “defaults” information from previous entries to successive progress notes.

- It was noted that some physical examinations were nearly identical on subsequent visits, even when there was a change in diagnosis(es).

Source: Trailblazer Medicare Sentinel No. 02-2S, Sept. 30, 2002
Computerized Documentation
Carrier Probe Review Findings (cont.)

- In addition, multiple patients had the exact same findings upon follow-up visits.
- Medicare is concerned that defaulted documentation may cause a provider to overlook significant new findings.
- Medicare is also concerned that the provider’s computerized documentation program defaults to a more extensive history and physical examination than is medically necessary to perform on a given day, and does not differentiate new findings and changes in a patient’s condition.

Source: Trailblazer Medicare Sentinel No. 02-2S, Sept. 30, 2002

Computerized Documentation
Carrier Probe Review Findings (cont.)

- If providers and their staff want to document electronically, they must ensure that the documentation accurately reflects the level of history, examination, and medical decision-making performed on a given day, and not information defaulted from a previous entry.
- Medicare only reimburses services according to the medical necessity of the patient’s condition on a specific date of service.

Source: Trailblazer Medicare Sentinel No. 02-2S, Sept. 30, 2002
What the Future Holds

Mark McCellan, MD, Internist
New Administrator for CMS states in his AMA Speech on March 30, 2004 in Washington DC:

“The road to a more streamlined billing system is through the use of electronic medical records software and electronic prescribing”.

E-prescribing will eventually help avoid medical errors and is included as a provision in the Medicare Prescription and Modernization Act (MMA)

Questions to Ask About …

- Does the form/template/EMR allow the provider to capture all levels of E/M services?
- Is the form/template driving the category of E/M code? Is it accurate?
- Does the form/template/EMR clearly illustrate what services were rendered?
- Can you determine the author(s)?
- Is it clear what body area(s) and/or organ system(s) were examined?
- Is the reason for the visit clearly stated or easily implied?
- Would another coder/auditor give credit the same way your organization does when conducting compliance audits?
Questions to Ask About … (cont.)

- Does the form/template/EMR prompt the user to document or check-off more than what was provided?
- Does the documentation illustrate the care rendered and the nature of the patients presenting illness?
- Does the form/template/EMR appear to be “treating the medical record” in order to achieve a higher level of service?

Discussion – Questions/Answers