Lessons Learned in the EHR
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AGENDA

• Documentation risks in an EMR
  o AHIMA Areas of Concern
  o Other Areas of Concern
  o ARRA Meaningful Use
• Example of Audit of cloning/copy & paste

FROM TESTIMONY OF LEWIS MORRIS, OIG

“For example, electronic health records (EHR) may not only facilitate more accurate billing and increased quality of care, but also fraudulent billing. The very aspects of EHRs that make a physician’s job easier—cut-and-paste features and templates—can also be used to fabricate information that results in improper payments and leaves inaccurate, and therefore potentially dangerous, information in the patient record. And because the evidence of such improper behavior may be in entirely electronic form, law enforcement will have to develop new investigation techniques to supplement the traditional methods used to examine the authenticity and accuracy of paper records.”

Underline added for emphasis
AHIMA AREAS OF CONCERN

DOCUMENTATION RISKS
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
http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_033097.hcsp
**DOCUMENTATION RISKS**

**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

**Guidelines for EHR Documentation to Prevent Fraud**
http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_033097.hcsp

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**CONCERN 1 - 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

CLONING

• Cloning
  • Cut & Paste = Blocks of text or even complete notes from another MD
  • Copy & Paste = Carry forward of prior notes
  • Other terms used =
    • Copy forward,
    • Re-use, and
    • Carry forward
COPY AND PASTE

• 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, per 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

• Examples:
  o Nurse was updating her resume (using Word) and copied a portion of her resume into a patient chart
  o ED nurse copied part of Patient A’s record into Patient B’s record—drug use and bi-polar diagnoses showed on Patient B’s medical record and billing information

• In an EMR, the error never truly goes away
TWO MACS’ POLICIES ON CLONING

First Coast Services Options, Inc.
• Cloned documentation does not meet medical necessity requirements for coverage of services rendered due to the lack of specific, individual information. All documentation in the medical record must be specific to the patient and her/his situation at the time of the encounter. Cloning of documentation is considered a 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 all overpayments made.

Cahaba Government Benefit Administrators LLC
• The medical necessity of services performed must be documented in the medical record and Cahaba would expect to see documentation that supports the medical necessity of the service and any changes and or differences in the documentation of the history of present illness, review of system and physical examination.

EXAMPLE OF COPY AND PASTE

• Patient presents for a routine follow up for diabetes. The RN reviews the patient’s current diabetic medication dose and asks if there are any other issues to discuss with the provider. The patient indicates no. The RN selects the "marked as reviewed" or "no changes" button in the review of systems section of the template. This action blows in the previous ROS from the prior encounter.
• The provider's diabetic template offers a detailed examination. The provider selects normal for all elements associated with the template. This detailed exam, combined with the carried-over ROS, that results in upcoding a routine follow up with standard lab orders to a 99214.
• The correct code for this visit is 99213 without the erroneous ROS and the mislabeled detailed exam.
EXPLODING NOTES: EXPLOSIVE TOPIC

• Check a box, get a sentence.
• Exploding notes and Natural Language Processing - reads and assigns code to the automated information.
  o Does not sort out Medically Necessary information
  o 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.”

CONCERN 2 - AUDITING INTEGRITY

• Authentication and amendment/correction issues
• Addition of more text to the same entry
• Auto authentication
• Lack of monitoring activity logs
AHIMA EHR GUIDELINES

- Access control functions
  - User authentication
  - Extensive privilege assignment and control features
- Capability to attribute the entry, modification or deletion of information to a specific individual or subsystem
- Capability to log all activity

AHIMA EHR GUIDELINES (CONT.)

- Capability to synchronize a common date and time across all components of the system
- Data entry editing
  - Verify validity of information on entry when possible,
  - Check for duplication and conflicts
  - Control and limit automatic creation of information
CONCERN 3 – 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: CHALLENGES

- Generate canned phrases, may 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. A VA 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.
LCD GUIDANCE ON TEMPLATES

- Noridian Administrative Services, LLC
  Documentation to support services rendered needs to be patient specific and date of service specific. These auto-populated paragraphs provide useful information such as the etiology, standards of practice, and general goals of a particular diagnosis. However, they are generalizations and do not support medically necessary information that correlates to the management of the particular patient. Part B MR is seeing the same auto-populated paragraphs in the HPIs of different patients. Credit cannot be granted for information that is not patient specific and date of service specific.


CMS MANUAL SYSTEM - MEDICARE PROGRAM INTEGRITY MANUAL

Chapter 3 - Verifying Potential Errors and Taking Corrective Action

“Some templates provide limited options and/or space for the collection of information such as by using "check boxes," predefined answers, limited space to enter information, etc. CMS discourages the use of such templates. Claim review experience shows that that limited space templates often fail to capture sufficient detailed clinical information to demonstrate that all coverage and coding requirements are met.

Physician/LCMPs should be aware that templates designed to gather selected information focused primarily for reimbursement purposes are often insufficient to demonstrate that all coverage and coding requirements are met. This is often because these documents generally do not provide sufficient information to adequately show that the medical necessity criteria for the item/service are met.”
CONCERN 4 - PATIENT IDENTIFICATION & DEMOGRAPHICS

• Demographic and insurance information may be defaulted for a patient’s encounter
• Patient identity theft is a vulnerable area

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?
OTHER RISK AREAS

- Monitoring of coding by EHR is not done
- Assume EHR coding matches billing system
- Coding “assistance” via the EMR product itself (CPT & ICD)
- Coding in EMR is valid although based on pre-determined design
- Lack of policies and procedures related to coding and documentation related to EHR
- Lack of EHR retention policies
OUTLINE

✓ WCMC – Billing Compliance Program Overview
✓ Focus on EHR Documentation
✓ New Term – “Cloned Note”
✓ Determining Scope
✓ Changing Behavior

Billing Compliance Scope

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<tr>
<td>Clinical Departments</td>
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<td>PO Billing Physicians/Providers</td>
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<td>Annual Visits</td>
<td>1.2 Million</td>
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<td>Annual Patient Services Rendered</td>
<td>2.8 Million</td>
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<td>E &amp; M</td>
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<tr>
<td>PROCEDURES</td>
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<tr>
<td>DIAGNOSTIC TESTS</td>
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<tr>
<td>Medicare</td>
<td>26%</td>
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<tr>
<td>Medicaid</td>
<td>11%</td>
</tr>
<tr>
<td>Other</td>
<td>9%</td>
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Audit Work Plan

PRE-BILLING REVIEWS
EVERY PROVIDER EVERY YEAR
ESCALATE FREQUENCY/INTENSITY BASED ON OUTCOMES
ADDITIONAL RISK BASED AUDITS
AUDIT ESCALATION POLICY

FOCUS ON EHR DOCUMENTATION

- NGS Medicare Bulletin – August 2012
- NY Times Article – September 2012
- HHS Letter – September 2012
- HHS Survey To Hospitals – October 2012
PHYSICIAN EHR WORKGROUP FORMED

1. **PURPOSE STATEMENT:** The workgroup was formed to evaluate current provider documentation practices in the electronic medical record that may result in documentation that is seen as “cloned notes” and recommend corrective action measures that can be implemented to eliminate such documentation practices.

2. **ACTIVITIES:**
   a. Review of Bulletins, Articles, Policies, Actions to Date
   b. Define scope of problem – Formalize method to capture data
   c. Measure the Scope of the Problem
   d. EHR workgroup validation
   e. Formulate corrective action plan(s)
DEFINE SCOPE – DATA CAPTURE METHODS

- Incorporate into ongoing billing compliance audits
- Focus on established patient/subsequent E/Ms (99231-99233 or 99211-99215)
- First established/subsequent encounter in audit sample
  - Compare patient’s current note to same physician/same patient previous encounter note
  - Print both notes
  - Fill out audit tool
  - Turn in for entry into database

PRELIMINARY AUDIT TOOL

<table>
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<tr>
<td>Department:</td>
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<tr>
<td>Provider:</td>
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</tr>
<tr>
<td>Case #:</td>
<td></td>
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<tr>
<td>Patient Last Name:</td>
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<td>Current DDS:</td>
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<td>First of pages of current DDS Note:</td>
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<td>Level of Service Suggested:</td>
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<td>Compared to Same Provider Previous DDS:</td>
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<td>Is the family history for the current date of service...</td>
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<td>Is the health history for the current date of service...</td>
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<td>Is the social history for the current date of service...</td>
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<td>Is the exam for the current date of service...</td>
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<td>Visit when accompanied</td>
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<td>Visit with same physician</td>
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AUDIT TOOL

To answer the questions on the EMR Tool Worksheet, you must compare the notes of the current DOS and the previous DOS by the same Provider.

(The comparison of the two notes is done to identify unique and/or cloned data in the current visit)

Scenario #1 – Final Outcome = 2 Key Areas of E/M Note Identical to Prior Visit Note
Step 1 — Select NO for the last question
Step 2 — Select YES to the violation on the left “2 Key Areas of E/M Note Identical to prior Visit Note”
Step 3 — Change the Support CPT Code to Zero
Step 4 — Click on “Finalize worksheet” to populate the “Finalize Worksheet” comment box shown below.
Step 5 — Click on YES to agree with the Support Code (0).
Step 7 — Double Click on the audit finding “Misuse of EMR – Policy Violation” (above) and the screen below will populate. You MUST add a comment with the DOS for the previous visit note and the number of pages of the current visit note.

EHR WORKGROUP VALIDATION
PRELIMINARY RESULTS
WORKGROUP VALIDATION OF DATA

- Reviewed database entries along with actual notes
- Observations:
  - Data speaks for itself
  - Emotionality removed through this process
  - Not too onerous to piggyback on existing audit process
  - Identified circumstances involving inappropriate use of EHR tools (templates, macros, copy forward functionality)
  - Other documentation rules – time for a refresher
  - Quality Implications
  - Billing Compliance Risks
WORKGROUP RECOMMENDATIONS

• One Message for all Clinical Providers – No Exemptions
• Memo from Associate Dean of Compliance
• Mandatory Education
• Ongoing Auditing for Same Patient/Same Physician Identical Entries in 2 out of 3 key elements [HPI, Exam, MDM]
  • High Risk Audit Finding
  • Immediate Communication to Provider When Identified
  • No billing allowed
News and Announcements

Responsible Documentation in the Electronic Health Record

Medical record documentation is required for patient care, coordination of care, quality reporting, research, peer review, billing, compliance and legal purposes. The highest professional standards are expected from all PHYSICIANS and care providers authorized to document in the patient's chart.

The issue of "slipped notes", which is broadly described as excessive identical or similar documentation in the electronic medical record of a patient, has made it into the OIG's work plan as well as the popular press (NYT, WSJ, etc.). OMS has issued the following statement concerning slipped notes: "Slipped documentation will be considered misrepresentation of the medical necessity requirement for coverage of services due to the lack of specific individual information for each unique patient. Identification of this type of documentation will lead to denial of services." Our University Professional Services Compliance Plan already includes a policy statement. (Read MORE)

Related Links

Billing Compliance Home
Research Billing Compliance Newsletter
General Billing Compliance Newsletter
MMC Compliance Plan & Policy Statements
Compliance Directory
Education
General Billing Compliance Guidelines
Research Billing Compliance Guidelines
Frequently Asked Questions
Forms

Contact

Office Location
410 East 71st Street - 4th Floor
New York, NY 10021

Mailing Address
325 East 68th Street - Box 44
New York, NY 10021

Professional Service Billing Compliance Plan - Oct Update
The compliance program described in this document is intended to be a framework for legal compliance by the University for its Medical College and

Agenda

The Electronic Medical Record (EMR)

Guidelines

Policies

Discuss the importance of appropriate documentation in the EMR

Outline and describe the ground rules to establish and maintain content integrity

Discover further resources for reference and support
REACTIONS FROM PROVIDERS

“It will be interesting to see if any of these recommendations make their way into actual EMR practice. At present, inpatient notes are still full of copied and pasted history and bloated with every radiologic test performed during the hospitalization. The actual assessment is often a sentence or two hidden toward the end of an enormous, pointless 17-page note.”

“Nicely done. Should be required of all residents, too!!!”

“This type of training should be done at the time of hiring, not years later, especially for those of us who are/were new to EMRs.”

“Well done. Would offer to medical students, as well.”

“I am delighted that all residents must take this course. Copy forwarding is posing significant challenges to notes that require significant feedback from faculty.”

COUNTERPOINTS

“I wish we could go back to paper!”

“I think we should minimize the number of quizzes, surveys and tests we need to take by simply auditing abusers of the charting system and making them remediate, instead of making everyone do this. Thank you.”

“This was worthless. A waste of time.”
APPEAL TO THE PROFESSIONALISM OF PROVIDERS

- This is as much about good care as it is about billing compliance
- Note writing is critical communication mechanism for providers
- Poor documentation puts patients at risk
- There is no perfect EHR system
- Like it or not, provider notes are used for billing
- Scrutiny from payers is increasing – reimbursement is threatened

- AGAIN, THIS IS ABOUT GOOD CARE

QUESTIONS?

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