Potential EHR Pitfalls for Physician Group Practices
William Dillon, JD, CHC, LHRM
Messer Caparello, P.A.
Jerry Williamson, MD, MJ, CHC, LHRM
Healthcare Network of Southwest Florida

Medicare and Medicaid EHR Incentive Program Overview

• The Medicare and Medicaid EHR Incentive Programs provide incentive payments to eligible professionals, eligible hospitals and critical access hospitals (CAHs) as they adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology. Eligible professionals can receive up to $44,000 through the Medicare EHR Incentive Program and up to $63,750 through the Medicaid EHR Incentive Program.

• Today’s presentation will focus on “eligible professionals”
  • MD/DO
  • DDS/DMD
  • DPM
  • OD
  • DC
  • Other
Overview of Incentive Payment Requirements

• For Stage 1 Eligible Providers

1. All 15 of the core measures
   Note: One of the required core measures is that EPs report clinical quality measures (CQMs)
2. 5 out of 10 of the menu measures; at least 1 public health measure must be selected
3. A sum total of up to 9 CQMs; 3 core, up to 3 alternate core, and 3 additional CQMs. If an EP reports a denominator of 0 for any of the 3 core measures, the EP must record for an alternate core CQM to supplement the core measure. Therefore, an EP may report a minimum of 6 and a maximum of 9 CQMs depending on the resulting values in the denominators for the core measures as reported from their certified EHR.

EHR Incentive Program Audits

• Eligible Providers should retain all relevant supporting source documentation – in either paper or electronic format used to support attestation as follows:
  • Documentation to support attestation data for meaningful use objective and clinical quality measures should be retained for six years post-attestation.
  • Documentation used to support payment calculation (such as cost report data) should follow the current documentation retention processes
    • Numerators and denominators for the measures;
    • Time period the report covers;
    • Evidence to support that it was generated for the EP.
## CMS Guidance

<table>
<thead>
<tr>
<th>Meaningful Use Objective</th>
<th>Audit Validation</th>
<th>Suggested Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug-Drug/Drug-Allergy</td>
<td>Functionality is available, enabled, and active in the system for the duration</td>
<td>One or more screenshots from the certified EHR system that are dated during the EHR</td>
</tr>
<tr>
<td>Interaction Checks and</td>
<td>of the EHR reporting period.</td>
<td>reporting period selected for attestation.</td>
</tr>
<tr>
<td>Clinical Decision Support</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Report ambulatory or</td>
<td>Clinical quality measure data is reported directly from certified EHR systems.</td>
<td>Report from the certified EHR system to validate all clinical quality measure data</td>
</tr>
<tr>
<td>hospital clinical quality</td>
<td></td>
<td>entered during attestation.</td>
</tr>
<tr>
<td>measures</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Meaningful Use Objective</th>
<th>Audit Validation</th>
<th>Suggested Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Electronic Exchange of</td>
<td>One text of certified EHR technology's capability to electronically exchange key</td>
<td>• Dated screenshots from the EHR system that document a test exchange of key clinical</td>
</tr>
<tr>
<td>Clinical Information</td>
<td>clinical information to another provider of care with a distinct certified EHR</td>
<td>information (successful or unsuccessful) with another provider of care during the</td>
</tr>
<tr>
<td></td>
<td>or other system capable of receiving information was performed during the EHR</td>
<td>reporting period.</td>
</tr>
<tr>
<td></td>
<td>reporting period.</td>
<td>• A dated record of successful or unsuccessful electronic transmission (e.g., email,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>a letter or email from the receiving provider confirming a successful</td>
</tr>
<tr>
<td></td>
<td></td>
<td>exchange, including specific information such as the date of the exchange, name of</td>
</tr>
<tr>
<td></td>
<td></td>
<td>providers, and whether the test was successful.</td>
</tr>
<tr>
<td>Protect Electronic Health</td>
<td>Security risk analysis of the certified EHR technology was performed prior to the</td>
<td>Report that documents the procedures performed during the analysis and the</td>
</tr>
<tr>
<td>Information</td>
<td>end of the reporting period.</td>
<td>results. Report should be dated prior to the end of the reporting period and should</td>
</tr>
<tr>
<td></td>
<td></td>
<td>include evidence to support that it was generated for that provider's system (e.g.,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>identified by National Provider Identifier (NPI), CMS Certification Number (CCN),</td>
</tr>
<tr>
<td></td>
<td></td>
<td>provider name, practice name, etc.)</td>
</tr>
<tr>
<td>Drug formulary Checks</td>
<td>Functionality is available, enabled, and active in the system for the duration</td>
<td>One or more screenshots from the certified EHR system that are dated during the EHR</td>
</tr>
<tr>
<td></td>
<td>of the EHR reporting period.</td>
<td>reporting period selected for attestation.</td>
</tr>
<tr>
<td>Generate Lists of Patients</td>
<td>One report listing patients of the provider with a specific condition.</td>
<td>Report from the certified EHR system that is dated during the EHR reporting period</td>
</tr>
<tr>
<td>by Specific Conditions</td>
<td></td>
<td>selected for attestation. Patient-identifiable information may be masked/blurred before</td>
</tr>
<tr>
<td></td>
<td></td>
<td>submission.</td>
</tr>
</tbody>
</table>
EHR Documentation and Professional Liability

**Potential Risks:**
- E-mail communications with patients
- Clinical Decision Support Systems
- Copy and paste functionality
- Templates
Secure Messaging Systems

E-mails:
• Response time may violate the standard of care.
• E-mail may create a written document of negligent advice.
• Patient satisfaction/dissatisfaction.
• Provider policy & informed consent
• AMA and AMIA Guidelines.

Clinical Decision Support Systems (CDSS)

• Clinical-decision support systems as evidence of standard of care
• Departure and negligence
• Overriding clinical support systems
• Systems that permit documenting reasons for overriding significant clerical alerts
• “Alert Fatigue”
Alert Fatigue

“A state of irritability, exhaustion or bewilderment triggered in clinicians who have been exposed to a large quantity of alerts or alerts with a perceived history of irrelevance, which causes the user to ignore some or all subsequent alerts, thereby reducing the safety benefit of the Clinical Decision Support System.”


Copy & Paste & Other Shortcuts*
*(AAMC Compliance Officers Forum,EHR Advisory#2, July 11, 2011)

*Copy & Paste: selecting data from an original or previous source to reproduce in another location.

*Cut & Paste: removing or deleting the original source text or data to place in another location.

*Cut and Paste should never be allowed as it alters the original source material.

*Copy Forward: a function that copies a significant section or entire prior note.

*Automated Change of Note Author: (similar to copy forward) changes authorship of a note written by someone else to current user of the note.
Copy & Paste & Other Shortcuts*
*(AAMC Compliance Officers Forum, EHR Advisory#2, July 11, 2011)

Template: documentation tools that feature predefined text and text options used to document the patient visit within a note.

Populating via Default: data is entered into a note via an electronic feature that does not require positive action or selection by author. For example, when documenting the Review of Systems in a patient history, an EHR may have functionality that enters the phrase “all other systems negative” without requiring the author to select a checkbox, or otherwise indicate that the work was performed.

Macro: expanded text that is triggered by abbreviated words or keystrokes. Not generally considered copy/paste, but rather abbreviating required keystrokes.

Provider Attitude Toward Copy and Paste

- Cross sectional survey
- Resident and faculty physicians at two academic medical centers
- 90% of physicians who wrote inpatient notes electronically used copy and paste functionality
- 70% used it almost always
- Inconsistencies and outdated information were common (71%) in notes containing copy and paste text.
- 80% wanted to continue to use copy and paste functionality.

(J. Gen Intern Med. 2009 January; 24(1):63-68)
Templates

• Medical records contain very similar or identical information.
• Automatic population of template data fields.
• Completion of templates in advance of the patient encounter.
• Subjective observations are limited or may go undocumented.

EHR Documentation and Fraud and Abuse

Potential Risks:
• Copy and paste functionality
• Templates
• Documentation and E&M coding
From Testimony of Lewis Morris, Chief Counsel, OIG:
As program integrity efforts become more technology driven, so will fraud.

“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.”

• September 24, 2012 Letter from Sec. Sebelius and Atty Gen. Holder to hospital industry.
  • “there are troubling indications that some providers are using this technology to game the system”
  • “False documentation of care is not just bad patient care: it’s illegal.”
  • “A patient’s care must be verified individually to ensure accuracy: it cannot be cut and pasted from a different record of the patient,”
  • “We will not tolerate health care fraud.”
OIG 2013 Work Plan

The 2013 OIG Work Plan identifies the following area of interest:

E&M services – Cloning of Electronic Medical Records:

In the 2013 Work Plan, the OIG notes “an increased frequency of medical records with identical documentation across services”.

• January 2014 – OIG – OEI-01-11-00571
  • CMS and Its Contractors Have Adopted Few Program Integrity Practices to Address Vulnerabilities in EHRs
  • Identified Risks
    • Copy-Pasting
    • Overdocumentation (auto-populate)
  • Emphasis on making use of Audit Logs
Medicare Administrator Contractor Policies
First Coast Service 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 overpayment made.

Impact of Copy and Paste on Documentation Integrity

1. Accuracy
2. Redundancy
3. Provider Confidence
CMS – No Reimbursement for Cloning

Cloning of Medical Notes

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. It would be expected that every patient had the exact same problem, symptoms, and required the exact same treatment.

Cloning of Medical Notes (cont’d)

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.

Documentation Risks

**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.

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

Guidelines for EHR Documentation to Prevent Fraud

---

**CMS Guidance:**

Medicare Program Integrity Manual (100-08) 3.3.2.1.1
3.3.2.1.1 - Progress Notes and Templates
(Rev. 455, Issued: 03-15-13, Effective: 12-10-12, Implementation: 03-21-13)

**A. Definitions**

For the purposes of Section 3.3.2.1.1, the following definitions apply:

1. **"Progress Notes"** -- visit notes, encounter notes, Evaluation and Management documentation, office notes, face-to-face evaluation notes or any other type of record of the services provided by a physician or other licensed/certified medical professional (LCMP) in the medical record. Progress notes may be in any form or format, hardcopy or electronic.

2. **"Template"** -- a tool/instrument/interface that assists in documenting a progress note. Templates may be paper or electronic. Electronic records may involve any type of interface including but not limited to:

   - simple electronic documents, sophisticated graphical user interfaces (GUIs) with clinical decision and documentation support prompts, or electronic pen capture devices.

   "Licensed/Certified Medical Professional (LCMP)" – Medical professional licensed or certified to practice in the state in which services are rendered. For the purposes of documenting DMEPOS items, the physician or LCMP must not have a financial relationship with the DMEPOS supplier.
B. Guidelines Regarding Which Documents Review Contractors Will Consider

The review contractor shall consider all medical record entries made by physicians and LCMPs. See PIM 3.3.2.5 regarding consideration of Amendments, Corrections and Delayed Entries in Medical Documentation. The amount of necessary clinical information needed to demonstrate that all coverage and coding requirements are met will vary depending on the item/service. See the applicable National and Local Coverage Determination for further details.

CMS does not prohibit the use of templates to facilitate record-keeping. CMS also does not endorse or approve any particular templates. A physician/LCMP may choose any template to assist in documenting medical information.

B. Guidelines Regarding Which Documents Review Contractors Will Consider cont’d

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 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.

If a physician/LCMP chooses to use a template during the patient visit, CMS encourages them to select one that allows for a full and complete collection of information to demonstrate that the applicable coverage and coding criteria are met.
Documentation and Evaluation and Management Coding (E&M)

- E&M Codes:
  - New Patients 99201 – 999205
  - Established Patients 99211 – 99215

- Levels of E/M Services:
  - Components
    - History
    - Physical Examination
    - Medical Decision Making
  - Key Components
  - Counseling
    - Coordination of Care
    - Nature of Presenting Problem
    - Time
  - Contributory Factors

Medical Necessity

Volume of Documentation vs. Medical Necessity

The Social Security Act, Section 1862 (a)(1)(A) states: “No payment will be made...for items or services...not reasonable and necessary for the diagnosis or treatment of an injury or illness or to improve the functioning of a malformed body member.” This medical reasonableness and necessity standard is the overarching criterion for the payment for all services billed to Medicare. Providers frequently “over document” and consequently select and bill for a higher-level E/M code than medically reasonable and necessary. Word processing software, the electronic medical record, and formatted note systems facilitate the “carry over” and repetitive “fill in” of stored information. Even if a “complete note is generated, only the medically reasonable and necessary services for the condition of the particular patient at the time of the encounter as documented can be considered when selecting the appropriate level of an E/M service.” Information that has no pertinence to the patient’s situation at that specific time cannot be counted.

EHR Impact on Documentation and Coding

• Provider expectations
• Audit results
• Medical necessity
• Encourage upcoding
• Complexity of medical decision making
• Automated documentation

Recommendations:

Improving documentation and coding functionality

• Audit protected
• Compliance enhanced
QUESTIONS?