Compliance Risks in the Electronic Medical Record

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We’ve come a long way – or have we?

“By computerizing health records, we can avoid dangerous medical mistakes, reduce costs, and improve care.”

President George W. Bush,
State of the Union Address
January 20, 2004
Issues

- Is meaningful use really meaningful?
- Is information available between entities?
- Is the quality of care improved – or even maintained?
- Is the health information secure?
- Are medically necessary services provided, documented, billed for, and reimbursed appropriately?

Balancing Medical Necessity and Meaningful Use

- Bringing forward medical history in an EMR is an important aspect of meaningful use
- Does this mean that you can count that comprehensive history toward the level of service for every encounter now and forevermore?
- What about medical necessity of elements? For example, vitals on every patient?
Physician Response

What do physicians dislike most about their EMR?
• 28.1% interferes with Face to Face/patient time
• 21.9% lack of clinical interoperability
• 18.8% slows down productivity

Physician Response

Study: What Do Physicians Read (and Ignore) in Electronic Progress Notes?
• Most attention given to Impression and Plan
• Very little attention given to vital signs, medication lists, and laboratory results

“Optimizing the design of electronic notes may include rethinking the amount and format of imported patient data as this data appears to largely be ignored.”

Applied Clinical Informatics
http://aci.schattauer.de/en/home/issue/special/manuscript/21088/show.html
Concerns with electronic records and overcoding

The Center for Public Integrity – September 2012
“coding levels may be accelerating in part because of increased use of electronic health records....”
“easy to create detailed patient files with just a few clicks”
“longer and more complex visits are easier to document”

Sebelius-Holder Letter
September 24, 2012
“False documentation of patient care is not just bad patient care; it’s illegal. The indications include potential ‘cloning’ of records in order to inflate what providers get paid.”

Congressional Response

October 4, 2012 letter to HHS Secretary Sebelius

“...your EHR incentive program appears to be doing more harm than good.”

Request –

• Suspension of EHR bonus payments and delay penalties for providers who don’t use EHR
• Increase what’s expected of meaningful users
• Block business practices that prevent exchange of information

OIG Workplan for 2012

“We will assess the extent to which CMS made potentially inappropriate payments for E/M services and the consistency of E/M medical review determinations. We will also review multiple E/M services for the same providers and beneficiaries to identify electronic health records (EHR) documentation practices associated with potentially improper payments. Medicare contractors have noted an increased frequency of medical records with identical documentation across services. Medicare requires providers to select the code for the service based upon the content of the service and have documentation to support the level of service reported.”
Previous OIG Reports

- 2011 – measured EHR use –
- 2012 – measured EHR use and specified which system

Neither study analyzed effectiveness or impact on coding

What are the auditors looking for?

- Authentication – signatures, dates/times – who did what? (metadata?)
- Contradictions – between HPI and ROS, exam elements and impression and plan
- Wording or grammatical errors/anomalies
- Medically implausible documentation
Code Generators

• Is the coding software programmed for the 1995 or 1997 Documentation Guidelines?
• Has the coding software been programmed to account for medical policies specific to the local Medicare contractor?
• How does the coding software manage dictated portions of the encounter such as History of Present Illness?
• How does the coding software distinguish between the levels of medical decision-making?

Templates

• Is the provider able to choose only part of a template or to personalize a template?
• Are there multiple templates, personalized for complaint or diagnosis?
• Are the various contributors to the encounter identified? Nursing staff, physician, etc.
Cloned 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 not be expected that every patient had the exact same problem, symptoms, and required the exact same treatment.

First Coast Service Options, Medicare Part B newsletter 2006
(Definitions published by Medicare contractors as early as 1999.)

Cloned Notes

November/December 1999 Medicare Bulletin: “Cloned notes are notes that have little or no change from day to day and patient to patient. These types of notes do not support the medical necessity of a visit. More importantly, in some cases, they may not actually support that a visit occurred. Cloned notes may be construed as an attempt to defraud the Medicare program.”
• Whether the documentation was the result of an Electronic Health Record, or the use of a pre-printed template, or handwritten documentation, cloned 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 for lack of medical necessity and the recoupment of all overpayments made.

— NGS Medicare -

Copy and Paste

AHIMA Position Statement – March 17, 2014
Called on industry stakeholders, EHR system developers, the public sector, and healthcare providers to work together to implement standards for the appropriate use of copy and paste
Why copy and paste?

“...most physicians use the functionality simply to save time. They have not been given the time and training needed to become fully proficient with their new systems, so they create workarounds to help them get through their day.”

Heather Haugen, PhD

“Overcoming the Risks of Copy and Paste in EHRs”

Journal of AHIMA, June 2014

June 2014 – JAMA Internal Medicine – University of Wisconsin School of Medicine and Public Health and the University of Wisconsin Hospital and Clinics:

• “it is too easy, and often mistaken, to equate a physician’s routine use of copy-and-paste with fraud. Data replication is a feature of electronic health records; facts beyond the mere use of duplicated text are required to establish that a note may be fraudulent.”

• It can be efficient and clinically useful when used properly, and that EHRs are “not to blame for the carelessness of individual physicians.”
Issues with Copy and Paste

• Outdated or redundant information
• Inability to identify the author or date of origin of information
• Unnecessarily lengthy notes
• Appearance of fraudulent activity – e.g., billing twice for the same “work”
• Quality of care and medico-legal integrity are compromised

Diagnosis Coding

• Have the physicians been educated in diagnosis coding?
• Has the diagnosis code listing been personalized for that practice and that physician?

As more physician payment mechanisms are based on severity of illness, correct and specific diagnosis coding becomes more important – to the physician.
Finalizing the Documentation

Code Selection

• Is the physician able to override the code selected by the EHR?

• Can he/she override the code to a higher level or only to a lower level of service?

Signatures

• Is the provider able to sign off on multiple items with one “sign-off” – multiple encounters, test results, phone calls, prescriptions

Timing of Billing

• Is the documentation complete before the encounter is billed?

• For ancillary services, is the bill “dropped” based when the order is entered or when the test is performed and results entered?
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