# Documentation Integrity: Best Practice Tips in the Era of Electronic Health Records

November 2, 2018

Roz Cordini
Senior Vice President
Director of Compliance Services

## EHR Documentation Integrity

Pertains to the accuracy of the complete legal record

Encompasses

- Information Governance
- Authorship Validation
- Patient Identification
- Amendments and Record Corrections
- Auditing to ensure documentation validity prior to submitting the claim for reimbursement

2

## EHR Documentation Integrity

Three Phases of Data Integrity in EHR Systems: Phase 1

Ensuring accurate data entry ("garbage in > garbage out")

- The three "Rs":
  - The *right* information
  - At the *right* time
  - For the *right* patient
- Use a coding system that links to internationally approved medical standards that are updated daily
- Avoid free text which is subject to human error

*See* "**Ensuring Data Integrity in Electronic Health Records: A Quality Health Care Implication**," by P. Vimalachandran, H. Wang, Y. Zhang, B. Heyward, F. Whittaker, submitted to Cornell University Library (2 Feb 2018).

## EHR Documentation Integrity

Three Phases of Data Integrity in EHR Systems: Phase 2

Ensuring data integrity by linking to the right patient

- Interoperability of EHRs depends on uniform patient identification method.
  - Social Security Number, currently the only universal unique identifier.
- Medicare is in the process of creating another unique identifier besides the SSN.

*See* "**Ensuring Data Integrity in Electronic Health Records: A Quality Health Care Implication**," by P. Vimalachandran, H. Wang, Y. Zhang, B. Heyward, F. Whittaker, submitted to Cornell University Library (2 Feb 2018).

## EHR Documentation Integrity

Three Phases of Data Integrity in EHR Systems: Phase 3

Ensuring data integrity by ensuring security from unauthorized alteration.

- Protecting from unauthorized access
- Unauthorized access > alterations that compromise data accuracy and reliability
  - Employees mistakenly or intentionally alter data
  - Hackers directly or indirectly alter data (e.g., ransomware, identity theft)
- Encryption, Block Chain, Pseudonymisation

*See* "**Ensuring Data Integrity in Electronic Health Records: A Quality Health Care Implication**," by P. Vimalachandran, H. Wang, Y. Zhang, B. Heyward, F. Whittaker, submitted to Cornell University Library (2 Feb 2018).

## EHR Documentation Integrity

- Information Governance

  "The accountability framework and decision rights to achieve enterprise information management"

- Patient Safety
- Quality
- Compliance
- Interoperability / Health Information Exchanges

6

## EHR Documentation Integrity

EHR Integrity Issues Directly Related to "Time-Saving" Features

- Cloning
- Copy & Paste
- Carry or Pull Forward Entries
- Auto-Fill
- Auto-Prompts
- Default suggestions during data entry
- Templates designed to meet reimbursement needs

## EHR Documentation Integrity

EHR Integrity Issues Related to System Design & Human Factors

- Patient Identification
- Author Integrity
- Data Validation After Dictation
- Record Amendments

## Integrity Issue: Cloning

"The word 'cloning' refers to documentation that is worded exactly like previous entries. This may also be referred to as 'cut and paste', 'copy and paste', or 'carried forward'. Cloned documentation may be handwritten, but generally occurs when using a preprinted template. . ."

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 the medical documentation is exactly the same for beneficiary to beneficiary. It would not be expected that every patient had the exact same problem, symptoms and required the exact same treatment. This "cloned documentation" does not meet medical necessity requirements for coverage of services rendered due to the lack of specific, individual information."

"Cloned documentation does not meet medical necessity requirements 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.***"

"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***." (emphasis added)

9

## Medical Necessity

- "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 service should be documented during, or as soon as practicable after it is provided in order to maintain an accurate medical record."

Medicare Claims Processing Manual, Ch. 12, Section 30.6.
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf

10

## Integrity Issue: Cloning (cont'd)

". . . But necessity is considered fraudulent if cloning of past medical services, lab and x-ray results, and medical notes from previous days, are simply reinserted into a new day's progress note to justify need."

"**Cloning**—This practice involves copying and pasting previously recorded information from a prior note into a new note, and it is a problem in health care institutions that is not broadly addressed. For example, features like auto-fill and auto-prompts can facilitate and improve provider documentation, but they can also be misused. ***The medical record must contain documentation showing the differences and the needs of the patient for each visit or encounter.*** Simply changing the date on the EHR without reflecting what occurred during the actual visit is not acceptable." (emphasis added)

"Providers using electronic records should conduct regular self-audits to be sure your documentation meets the above mentioned criteria.

https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/docmatters-ehr-providerfactsheet.pdf
Electronic Medical Record Tips When Using Electronic Medical Records, September 6, 2012.
https://cgsmedicare.com/partb/pubs/news/2012/0812/cope19795.html

11

## Integrity Issue: Cloning

(Copy/Paste, Carry/Pull Forward)

Example: Nurse turned patient every two hours during her shift, and she copied and pasted her previous nursing progress notes every two hours. Each note said "patient positioned on her left side." Patient developed pressure ulcer.

## CGS Post Payment Probe Review Letters

**REASON FOR REVIEW**
Our data analysis for July 2013-June 2014 finds your utilization of CPT code(s) 99214(Established office care) exceeds the norms of your peers in specialty 06. Data for dates of service 07/01/2013 - 06/30/2014 was reviewed and you are one of the highest billers of CPT code 99214 in Kentucky; therefore, a post pay probe review of your services is being conducted.

Based on the medical documentation reviewed for the selected claims, we found that some services you submitted were not reasonable and necessary, as required by the Medicare statute, or did not meet other Medicare coverage requirements. Along with our claims payment determination, we have made limitation

**Probe Review Findings:**

- Documentation does not support level of service
- Documentation did not support medical necessity – lack of individualized documentation
- EMR records appear to have cloning in all 3 key elements
- Inappropriate billing Modifier 25 and global days XXX
- Billing Evaluation and Management within 90 day global

13

## Integrity Issue: Templates

- A well-designed EHR template enhances compliance and patient care & safety if it:
  - Incorporates care guidelines
  - Incorporates mnemonics to help deliver evidence-based care
  - Automates reminders and investigations
  - Recommends appropriate tests and flags inappropriate ones
  - Enhances compliance with standards, policies and procedures

14

## Integrity Issue: Templates

- But . . . they can pose risks if they:
  - Are not flexible and may not clinically fit the situation
  - Lack safeguards against presenting an inaccurate picture of patient's condition at admission or over time
  - Create an redundancy or "over-documentation" situation
  - Are designed to meet reimbursement needs in a way that could be perceived as fraudulent

## Integrity Issue: Overdocumentation

"Over-documentation is the practice of inserting false or irrelevant documentation to create the appearance of support for billing higher level services. Some [EHR's] auto-populate fields when using templates built into the system. Other systems generate extensive documentation on the basis of a single click of a checkbox, which if not appropriately edited by the provider may be inaccurate. ***Such features produce information suggesting the practitioner performed more comprehensive services than were actually rendered.****" (emphasis added)*

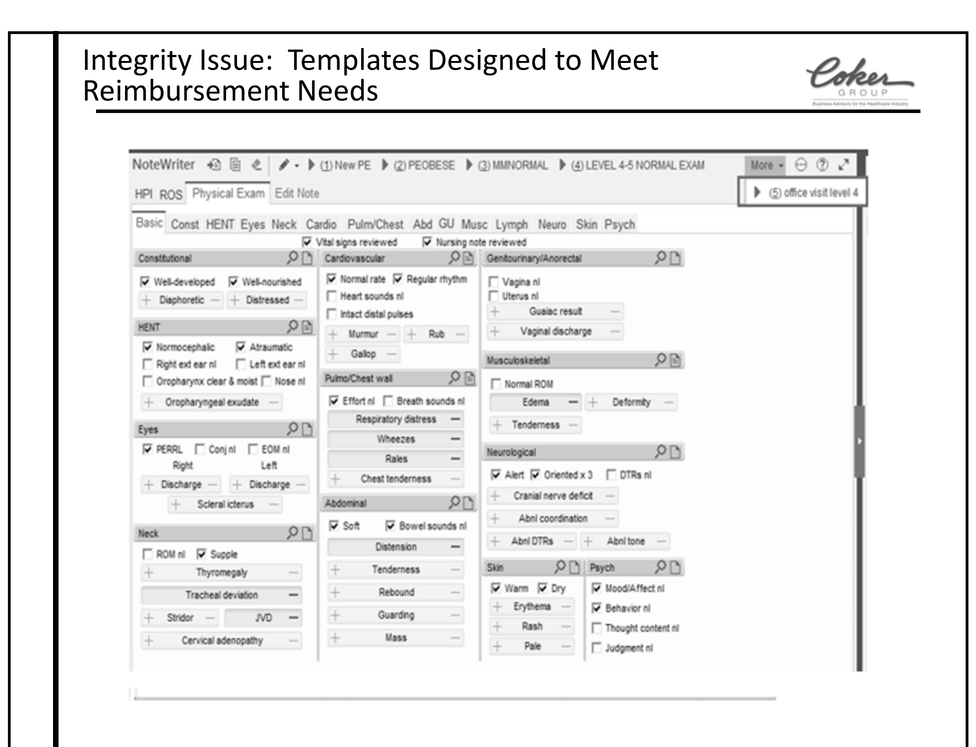
16

## Integrity Issue: Auto-Fill & Default Suggestions

**CMS Electronic Health Records Provider Fact Sheet:**

- "[F]eatures like auto-fill and auto-prompts can facilitate and improve provider documentation, but they can also be misused."
- Clinical record must document the differences and needs of the patient for each visit or encounter.
- Recommendation: Use electronic signature or personal identification number (PIN) to help deter possible fraud, waste, and abuse that can occur with EHR use.

## Integrity Issue: Templates Designed to Meet Reimbursement Needs



## Integrity Issue: Templates

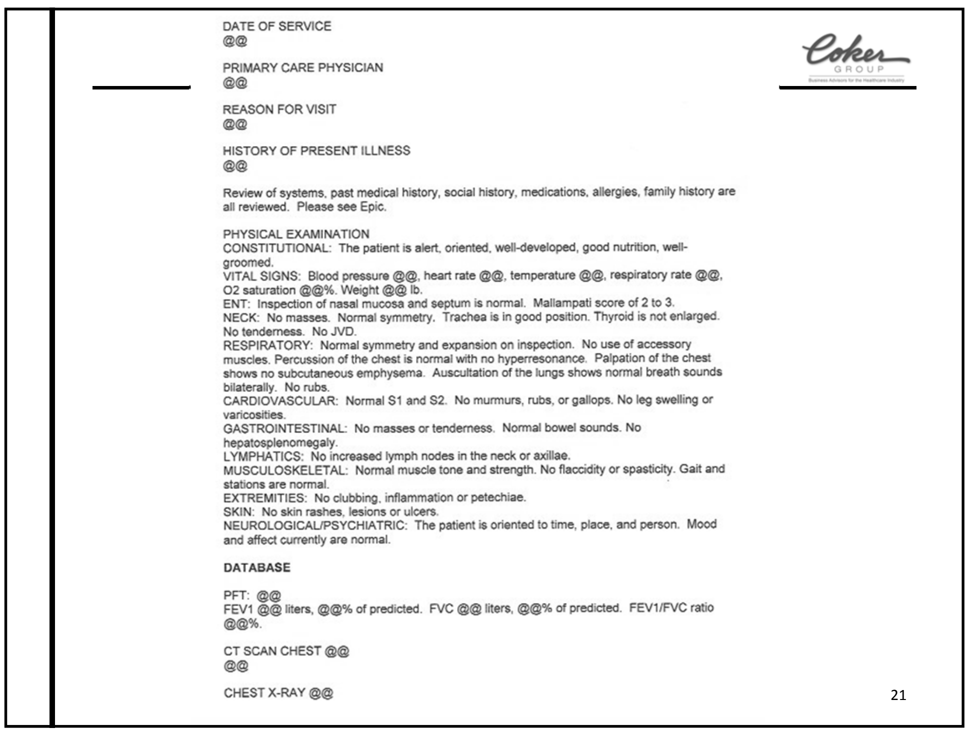
- Automatic Negatives
  - Charting by exception concept
  - Data element must be changed in order to document a positive finding
  - Record documentation may be conflicting if the provider forgets to uncheck a box or delete an automatically generated negative
  - Ex. Patient in hospital for GI bleed; provider uses an automatically generated "normal" ROS template; provider forgets to edit section documenting the normal GI exam

19

## Integrity Issue: Templates

- Automatically generated findings (+ or -)
  - "Providers should be wary of templates that have pre-printed information indicating certain "comprehensive" level services were performed"
    - WPS Medicare

20



DATE OF SERVICE
@@

PRIMARY CARE PHYSICIAN
@@

REASON FOR VISIT
@@

HISTORY OF PRESENT ILLNESS
@@

Review of systems, past medical history, social history, medications, allergies, family history are all reviewed. Please see Epic.

PHYSICAL EXAMINATION
CONSTITUTIONAL: The patient is alert, oriented, well-developed, good nutrition, well-groomed.
VITAL SIGNS: Blood pressure @@, heart rate @@, temperature @@, respiratory rate @@, O2 saturation @@%. Weight @@ lb.
ENT: Inspection of nasal mucosa and septum is normal. Mallampati score of 2 to 3.
NECK: No masses. Normal symmetry. Trachea is in good position. Thyroid is not enlarged. No tenderness. No JVD.
RESPIRATORY: Normal symmetry and expansion on inspection. No use of accessory muscles. Percussion of the chest is normal with no hyperresonance. Palpation of the chest shows no subcutaneous emphysema. Auscultation of the lungs shows normal breath sounds bilaterally. No rubs.
CARDIOVASCULAR: Normal S1 and S2. No murmurs, rubs, or gallops. No leg swelling or varicosities.
GASTROINTESTINAL: No masses or tenderness. Normal bowel sounds. No hepatosplenomegaly.
LYMPHATICS: No increased lymph nodes in the neck or axillae.
MUSCULOSKELETAL: Normal muscle tone and strength. No flaccidity or spasticity. Gait and stations are normal.
EXTREMITIES: No clubbing, inflammation or petechiae.
SKIN: No skin rashes, lesions or ulcers.
NEUROLOGICAL/PSYCHIATRIC: The patient is oriented to time, place, and person. Mood and affect currently are normal.

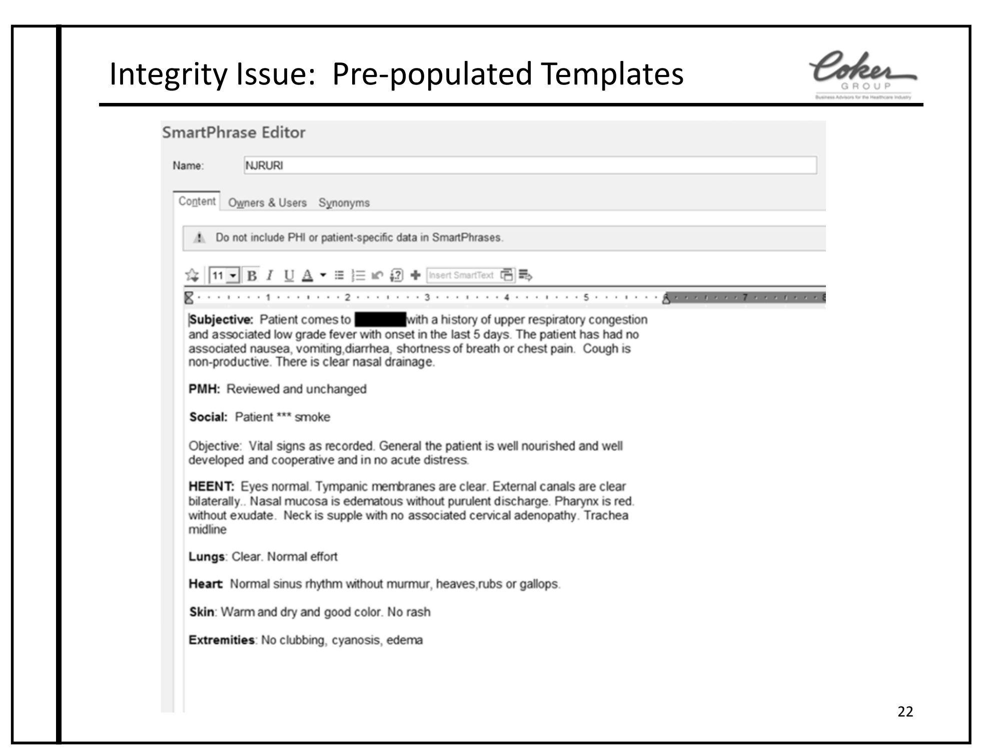
**DATABASE**

PFT: @@
FEV1 @@ liters, @@% of predicted. FVC @@ liters, @@% of predicted. FEV1/FVC ratio @@%.

CT SCAN CHEST @@
@@

CHEST X-RAY @@

21



## Integrity Issue: Pre-populated Templates

SmartPhrase Editor

Name: NJRURI

Content Owners & Users Synonyms

Do not include PHI or patient-specific data in SmartPhrases.

**Subjective:** Patient comes to [redacted] with a history of upper respiratory congestion and associated low grade fever with onset in the last 5 days. The patient has had no associated nausea, vomiting,diarrhea, shortness of breath or chest pain. Cough is non-productive. There is clear nasal drainage.

**PMH:** Reviewed and unchanged

**Social:** Patient *** smoke

Objective: Vital signs as recorded. General the patient is well nourished and well developed and cooperative and in no acute distress.

**HEENT:** Eyes normal. Tympanic membranes are clear. External canals are clear bilaterally.. Nasal mucosa is edematous without purulent discharge. Pharynx is red. without exudate. Neck is supple with no associated cervical adenopathy. Trachea midline

**Lungs**: Clear. Normal effort

**Heart**: Normal sinus rhythm without murmur, heaves,rubs or gallops.

**Skin**: Warm and dry and good color. No rash

**Extremities**: No clubbing, cyanosis, edema

22

## Integrity Issue: Pre-populated Templates

SmartPhrase Editor

Name: NJRR4

Content | Owners & Users | Synonyms

Do not include PHI or patient-specific data in SmartPhrases.

SUBJECTIVE:
Pt presents with a history of upper respiratory congestion and cough. Cough is productive of some yellowish green sputum. The patient has also had associated low grade fever. There is no chest pain but has had some malaise and generalized myalgias. The patient has no shortness of breath or chest pain. No significant sinus or nasal drainage. No improvement with over-the-counter medications

ROS: Systems reviewed by this provider and pertinent positives and negatives are recorded in Subjective

PMH/FH: Reviewed by this provider and updated as appropriate

SOCIAL HISTORY: The patient {Action; does/does not:19097} smoke.

OBJECTIVE:

Vital signs as recorded. General: The patient is well nourished, well developed, and cooperative in no acute distress.

HEENT: Eyes are normal. Tympanic membranes are clear. Examination of the external canals is unremarkable. Nasal mucosa is unremarkable. Pharynx is mildly injected.

Neck: Supple. There is no significant lymphadenopathy. Trachea midline

Lungs: {Exam; lung:16931::"clear to auscultation bilaterally"}. Normal effort

Heart: Normal sinus rhythm without murmurs, heaves, rubs, or gallops.

Extremities: No obvious edema. No clubbing or cyanosis

Skin: Without obvious rashes. Warm and dry. Color good

23

## Documentation Guidelines

**1995 Documentation Guidelines**

- A ROS and/or a PFSH obtained during an earlier encounter does not need to be re-recorded <u>if there is evidence that the physician reviewed and updated the previous information</u>. This may occur when a physician updates his/her own record or in an institutional setting or group practice where many physicians use a common record. The review and update may be documented by:
  - describing any new ROS and/or PFSH information or noting there has been no change in the information; and
  - noting the date and location of the earlier ROS and/or PFSH.
- The ROS and/or PFSH may be recorded by ancillary staff or on a form completed by the patient. To document that the physician reviewed the information, <u>there must be a notation supplementing or confirming the information recorded by others</u>.
- A complete ROS inquires about the system(s) directly related to the problem(s) identified in the HPI plus all additional body systems.
  - At least ten organ systems must be reviewed. Those systems with positive or pertinent negative responses must be individually documented. For the remaining systems, a notation indicating all other systems are negative is permissible. In the absence of such a notation, at least ten systems must be individually documented.
- The extent of examinations performed and documented is dependent upon clinical judgment and the <u>nature of the presenting problem(s).</u> They range from limited examinations of single body areas to general multi-system or complete single organ system examinations.

24

## Integrity Issue: Templates

### Default time statements

- "Instruct physicians to select the code for the service based upon the content of the service. The duration of the visit is an ancillary factor and does not control the level of service to be billed unless more than 50% of the face to face time (for non-inpatient services) or 50% of the floor time (for inpatient services is spent providing counseling or coordination of care . . ."
- "Time spent counseling the patient or coordinating the patient's care after the patient has left the office or the physician has left the patient's floor or begun to care for another patient on the floor is not considered when selecting the the level of service to be reported."
- If the physician elects to report the level of service based on counseling and/or coordination of care, the total length of time of the encounter (face-to-face or floor time, as appropriate) should be documented and the record should describe the counseling and/or activities to coordinate care.

Medicare Claims Processing Manual, Ch. 12, Section 30.6.
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf

25

## Default Time Statements

@AMBTOB@

**BILLING ATTESTATION (NEW PATIENT CONSULTATION):**

**I have spent 45 minutes in new patient consultation time in the management of @NAME@ today, @TODAYDATE@. In addition to the time I spent evaluating and treating @NAME@, I spent time reviewing test results and imaging studies, and discussing and coordinating complex medical decisions with medical and nursing staff. Greater than 50% of the time was**

**BILLING ATTESTATION:**

I have spent 25 minutes of time in the management of @NAME@ today, @TODAYDATE@. In addition to the time I spent evaluating and treating @NAME@, I spent time reviewing test results and imaging studies, and discussing and coordinating complex medical decisions with medical and nursing staff. Greater than 50% of the time was spent face to face with the patient. The complexity of the illness has been documented.

26

## Slide 26

**MOU3** Shadow program?
Microsoft Office User, 10/7/2018

**MOU4** Does the schedule match up?
Microsoft Office User, 10/7/2018

## Default Statements in General

KASPER reviewed. Discussed risks and benefits of use of controlled substance with @NAME@. Discussed risk of tolerance and drug dependence.

Diet, Exercise, and Smoking Cessation strategies have been discussed at length with the patient.

**Lipids** have been reviewed with patient if managed by [redacted] [redacted] - LDL goal is {LDL recommendations:21556} and HDL goal is {HDL recommendations:21555}

**If Diabetic**, it is being managed by Primary Care Provider or Endocrinologist. Importance of appropriate diabetic control in the management of Cardiovascular Disease stressed to patient - prognostic significance of last Hb1Ac explained (Last Hb1Ac where available has been noted ).

27

## Integrity Issue: Cloning

***AHIMA Position***: Weigh efficiency and time savings against potential for inaccurate, fraudulent, unwieldy documentation. Use only in presence of strong technical and administrative controls. Safety actions to consider:

- Organizational policies and procedures addressing proper use, considering gov’t, regulatory and industry standards
- Comprehensive user training and education
- Ongoing monitoring and enforcement of compliance

## Integrity Issue: Cloning

***The Joint Commission (TJC) Patient Safety Alert – "Preventing copy-and-paste errors in EHRs" (Feb 2015)***

- Weigh benefits (improved efficiencies) against risks:
  - Inaccurate or outdated data
  - Redundancy > difficult to identify current information
  - Inability to identify author and intent
  - Inability to identify when data was first created
  - Propagation of false information
  - Internally inconsistent progress notes
  - Unnecessarily lengthy progress notes

## Integrity Issue: Cloning

***TJC Safety Alert (cont.) – Safety Actions to Consider:***

- TJC endorsed AHIMA's safety actions recommended & added:
  - Work collaboratively with health care providers, medical societies and others to balance benefits & risks and develop training & education;
  - Monitor accuracy of clinical record & solicit provider feedback for addressing inaccurate or overly redundant documentation;
  - Conduct focused, ongoing professional performance evaluation with ties to clinical record accuracy;
  - Maintain robust quality review process for EHR misuse & errors – evaluate & identify patient safety improvement opportunities.

# Integrity Issue: Cloning

***Additional Resources on Cloning:***

- OIG Studies on EHR Integrity – December 2013 and January 2014 (highlights the important role of audit logs)
- AMA Study: "Characterizing the Source of Text in Electronic Health Record Progress Notes," JAMA Intern Med. (Aug 2017)
- NIST Study: "Examining the 'Copy and Paste' Function in the Use of Electronic Health Records," NISTIR 8166 (Jan. 2017)

# ECRI Partnership for Health IT

Patient Safety: Copy and Paste

The Partnership makes ***four safe practice recommendations***:

A. Provide a mechanism to make copy and paste material easily identifiable.

B. Ensure that the provenance of copy and paste material is readily available.

C. Ensure adequate staff training and education regarding the appropriate and safe use of copy and paste.

D. Ensure that copy and paste practices are regularly monitored, measured, and assessed.

See https://www.ecri.org/HITPartnership/Pages/Safe-Practices.aspx

## Integrity Issue: Author Integrity

- CMS warns: “Different providers may add information to the same progress note. When this occurs, each provider should be allowed to sign his or her entry, allowing verification of the amount of work performed and which provider performed the work.”

## Integrity Issue: Author Integrity

- AHIMA tips to protect author integrity:
  - Verify authorship by selecting biometric identifier, PIN, badge or other unique identifier + password as log-in ID.
  - Establish policies requiring staff to protect log-in IDs and passwords and report breaches ASAP.
  - Implement access controls to ensure users have the authority to view and enter information on a record.
  - Retain original author identification and original entry date for a cloned record.
  - Ensure audit logs track date, time and users.
  - Assign responsibility for auditing logs.

## Integrity Issue: Record Amendment

- AHIMA toolkit, "Amendments in the Electronic Health Record," provides guidance on maintaining the integrity and accuracy of an EHR. Best practices include adopting procedures on:
  - Addendums
  - Corrections
  - Late Entries
  - Retractions
  - Deletions, and
  - Re-sequencing or Reassignment

**Other**
**EHR Integrity**
**Examples**

## Integrity Issue: Delayed Validation of Dictation Transcription

- Example: Radiologist dictated report and the un-validated report was relied upon. Later, when the radiologist validated the report, he added a crucial “not” within the data entry, completely reversing the meaning of the report.
- *Establish process to ensure providers review, edit, and approve dictation in a timely manner.*
- *Ensure all draft, un-validated reports, are clearly marked.*

VALIDATED

## EHR Integrity Example: Clinical Notes & Date Association

- Date & time of service and date & time of entry are both important.
- Example: Physician examines patient on 5/23 and enters note on 5/25 that patient is allergic to drug X; another physician prescribes drug X on 5/24 without the benefit of the first physician’s 5/25 note of the drug allergy.
- *Late entries should be noted.*

## EHR Integrity Example: EHR Entry Date/Time *versus* the Peripheral Device Date/Time

- Example: Facility has multiple peripherals tied to the EHR, but each one shows a different time. ECG ordered for patient with chest pain at 1:00p and ECG performed at 1:09p, but ECG clock is wrong and shows performed at 1:39p. This is outside best practice window of 10 minutes and may not be reimbursed.
- *Verify that EHR and all peripherals are linked and automatically enter correct date/time stamp.*

## ECRI Partnership for Health IT Patient Safety: I-C-E

The Partnership makes ***three safe practice recommendations*** for developing, implementing, and integrating a health IT safety program:

1. **Integrate**: Identify ways to integrate health information technology (IT) safety into existing safety programs.
2. **Collaborate**: Convene the necessary stakeholders, including users, vendors, organizations, and patients to actively collaborate on safety.
3. **Embed:** Embed safety into the culture and daily workflow to achieve a unified vision of health IT safety.

See https://www.ecri.org/HITPartnership/Pages/Safe-Practices.aspx

# EHR Data Integrity Liability Risks

## EHR Data Integrity Liability Risks

- **Theories of Liability**
  - Negligence
  - Fraud
  - Qui Tam

## EHR Data Integrity Liability Risks: False Claims

- Federal & State Health Care Program False Claims
- Civil Monetary Penalties Liability
- OIG and NIST studies

## EHR Data Integrity Liability Risks: Commercial Payors

- Commercial Payor Fraud
- Breach of Contract Liability

## EHR Data Integrity Liability Risks: Other Risks

- HIPAA fines and penalties
- State or Accreditation survey deficiency findings
- Loss of Accreditation

# EHR Documentation Integrity Best Practices

## Best Practices for EHR Documentation Integrity

- Perform EHR Data Audits
  - Review provider templates
  - Provide meaningful suggestions to providers to improve templates
  - Collect examples of poor/problematic documentation
- Establish EHR Integrity Program
  - Identify physician champions early
  - Obtain provider input

## Best Practices for EHR Documentation Integrity

- Develop an EHR Integrity Policy & Procedure
- Enforce EHR Documentation Policies & Procedures
- Utilize EHR Built-in Safeguards
- Identify Safeguard Gaps & Work with Vendor to Address Gaps
- Establish Process for Logging and Auditing EHR Activity

## Best Practices for EHR Integrity cont'd

- Train EHR Users on the EHR Integrity Program Policies & Procedures:
  - EHR Security Requirements
  - EHR Documentation Requirements
  - Personal Responsibility for Security & Integrity
- Enforce Disciplinary Policies for Violations
- Review and Keep Abreast of Publications on EHR Integrity: Government (CMS, OIG, NIST); Industry (AHIMA, AMA); Patient Safety Focused (TJC, ECRI).

# Questions?

50