Lessons Learned in the EHR

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AGENDA

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

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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. "

http://oig.hhs.gov/testimony/docs/2011/morris_testimony_07122011.pdf
Underline added for emphasis

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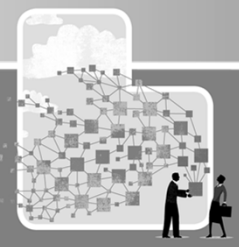
AHIMA AREAS OF CONCERN



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

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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

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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

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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

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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."

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COPY AND PASTE

- Examples:
  - Nurse was updating her resume (using Word) and copied a portion of her resume into a patient chart
  - 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

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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

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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.

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EXPLODING NOTES: EXPLOSIVE TOPIC

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

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CONCERN 2 - AUDITING INTEGRITY

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

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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

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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

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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

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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.

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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.

  Source: https://www.noridianmedicare.com/shared/partb/bulletins/2011/271_jul/Evaluation_and_Management_Services_-_Documentation_and_Level_of_Service_.htm

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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."

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CONCERN 4 - PATIENT IDENTIFICATION & DEMOGRAPHICS

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

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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?

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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

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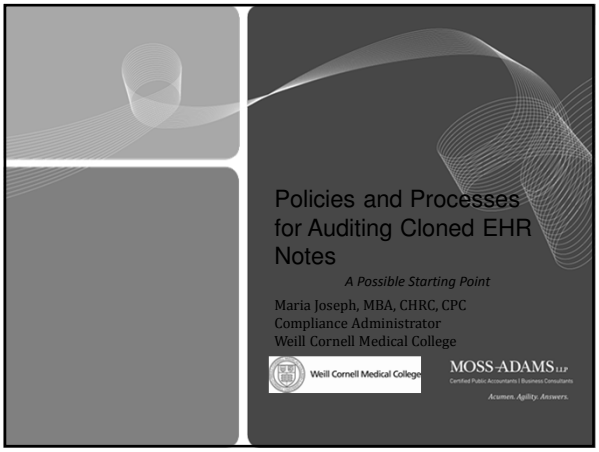

OUTLINE

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

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Billing Compliance Scope

Clinical Departments	21
PO Billing Physicians/Providers	795
Annual Visits	1.2 Million
Annual Patient Services Rendered	2.8 Million

Service Mix		Payer Mix	
E & M	40%	Managed Care	54%
PROCEDURES	34%	Medicare	26%
DIAGNOSTIC TESTS	26%	Medicaid	11%
		Other	9%

Audit Work Plan

PRE-BILLING REVIEWS

EVERY PROVIDER EVERY YEAR

ESCALATE FREQUENCY/INTENSITY BASED ON OUTCOMES

ADDITIONAL RISK BASED AUDITS

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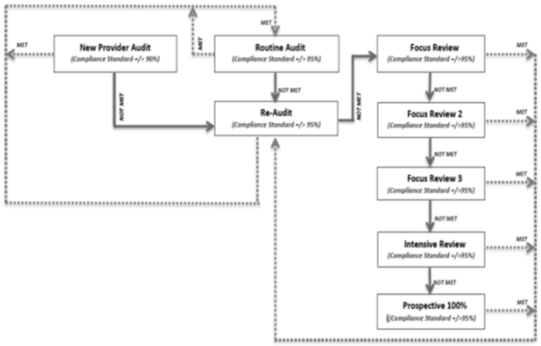
AUDIT ESCALATION POLICY



FOCUS ON EHR DOCUMENTATION

- OIG Work Plan – 2011 & 2012
- NGS Medicare Bulletin – August 2012
- NY Times Article – September 2012
- HHS Letter – September 2012
- HHS Survey To Hospitals – October 2012

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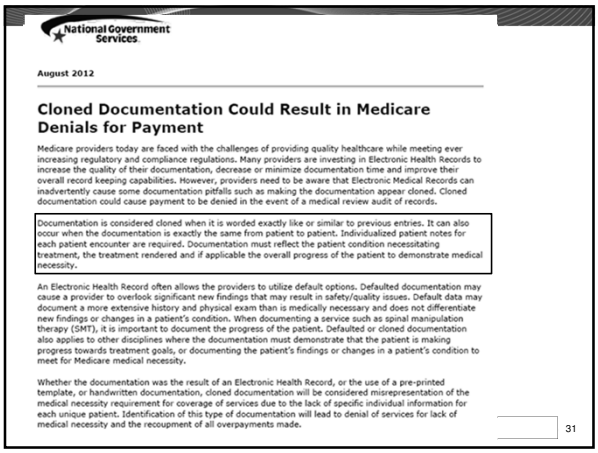

National Government Services

August 2012

Cloned Documentation Could Result in Medicare Denials for Payment

Medicare providers today are faced with the challenges of providing quality healthcare while meeting ever increasing regulatory and compliance regulations. Many providers are investing in Electronic Health Records to increase the quality of their documentation, decrease or minimize documentation time and improve their overall record keeping capabilities. However, providers need to be aware that Electronic Medical Records can inadvertently cause some documentation pitfalls such as making the documentation appear cloned. Cloned documentation could cause payment to be denied in the event of a medical review audit of records.

Documentation is considered cloned when it is worded exactly like or similar to previous entries. It can also occur when the documentation is exactly the same from patient to patient. Individualized patient notes for each patient encounter are required. Documentation must reflect the patient condition necessitating treatment, the treatment rendered and if applicable the overall progress of the patient to demonstrate medical necessity.

An Electronic Health Record often allows the providers to utilize default options. Defaulted documentation may cause a provider to overlook significant new findings that may result in safety/quality issues. Default data may document a more extensive history and physical exam than is medically necessary and does not differentiate new findings or changes in a patient's condition. When documenting a service such as spinal manipulation therapy (SMT), it is important to document the progress of the patient. Defaulted or cloned documentation also applies to other disciplines where the documentation must demonstrate that the patient is making progress towards treatment goals, or documenting the patient's findings or changes in a patient's condition to meet for Medicare medical necessity.

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.

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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)

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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

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PRELIMINARY AUDIT TOOL

Reviewed by:	
Audit Month:	
Audit Mode:	
Department:	
Provider:	
Case #:	
Patient Last Name:	
Current DOS:	
Total # of pages of current DOS Note:	
Level of Service Supported:	
Compared to Same Provider Previous DOS:	

Based on _____History _____Exam _____MDM _____Time

	X	Choose one for each E/M Component	Comments
Is the HPI for the current date of service...		unique when compared to previous visit	
		identical to previous DOS	
		similar to previous DOS with some modification	
		not documented	
Is Past Medical History for the current date of service...		unique when compared to previous visit	
		identical to previous DOS	
		similar to previous DOS with some modification	
		not documented	
Is the Family History for the current date of service...		unique when compared to previous visit	
		identical to previous DOS	
		similar to previous DOS with some modification	
		not documented	
Is the Social History for the current date of service...		unique when compared to previous visit	
		identical to previous DOS	
		similar to previous DOS with some modification	
		not documented	
Is the ROS for the current date of service...		unique when compared to previous visit	
		identical to previous DOS	
		similar to previous DOS with some modification	
		not documented	
Is the Exam for the current date of service...		unique when compared to previous visit	
		identical to previous DOS	
		similar to previous DOS with some modification	
		not documented	
Is the MDM for the current date of service...		unique when compared to previous visit	
		identical to previous DOS	
		similar to previous DOS with some modification	
		not documented	

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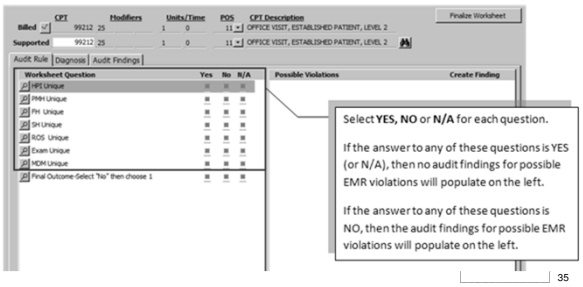
AUDIT TOOL

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

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



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Scenario #1 – Final Outcome = 2 Key Areas of E/M Note Identical to Prior Visit Note

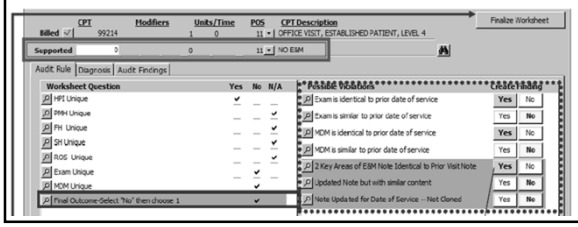
Step 1— Select **NO** for the last question

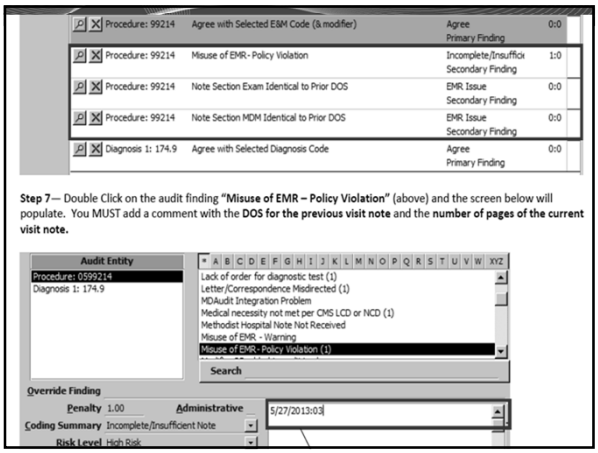
Step 2— Select **YES** to the violation on the left ***"2 Key Areas of E&M Note Identical to prior Visit Note"***

Step 3—Change the Support CPT Code to Zero

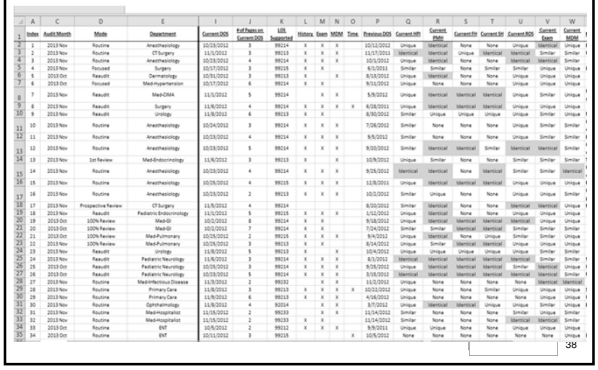
Step 4— Click on **"Finalize worksheet"** to populate the "Finalize Worksheet" comment box shown below.

Step 5— Click on **YES** to <u>agree</u> with the Support Code (0).





EHR WORKGROUP VALIDATION
PRELIMINARY RESULTS



Index	Audit Month	Mode	Department	Current DOS	# of Pages on Current DOS	LOS Supporting	History	Exam	MDM	Time	Previous DOS	Current HPI	Current PMH	Current FH	Current SH	Current ROS	Current Exam	Current MDM
1	2013 Nov	Routine	Anesthesiology	10/23/2012	3	99214	X	X	X		10/12/2012	Unique	Identical	Identical	None	Unique	Identical	Unique
2	2013 Nov	Routine	CT Surgery	11/1/2012	3	99213	X	X	X		11/17/2011	Identical	Identical	Unique	Identical	Identical	Similar	Similar
3	2013 Nov	Routine	Anesthesiology	10/23/2012	4	99214	X	X	X		10/1/2012	Unique	Identical	None	None	Identical	Identical	Similar
4	2013 Nov	Focused	Surgery	10/17/2012	3	99235	X	X			6/1/2011	Similar	Similar	None	None	Similar	Similar	Unique
5	2013 Oct	Focused	Dermatology	10/31/2012	3	99213	X			X	8/13/2012	Unique	Identical	None	None	Unique	Unique	Unique
6	2013 Oct	Focused	Med-Hypertension	10/17/2012	6	99214	X	X			9/11/2012	Unique	None	None	None	Unique	Unique	Unique
7	2013 Nov	Readult	MedONA	11/1/2012	5	99214		X	X		5/8/2012	Unique	Identical	Identical	Identical	Unique	Similar	Unique
8	2013 Nov	Readult	Surgery	11/8/2012	4	99214	X	X	X	X	6/28/2011	Unique	Identical	Identical	Identical	Unique	Unique	Unique
9	2013 Nov	Readult	Urology	11/8/2012	6	99213	X	X			8/30/2012	Similar	Unique	Unique	Unique	Unique	Similar	Unique
10	2013 Nov	Routine	Anesthesiology	10/24/2012	3	99214	X	X	X		7/26/2012	Similar	None	None	None	Unique	Similar	Similar
11	2013 Nov	Routine	Anesthesiology	10/23/2012	4	99214	X	X	X		9/5/2012	Similar	None	None	None	Unique	Similar	Similar
12	2013 Nov	Routine	Anesthesiology	10/23/2012	5	99214	X	X	X		9/20/2012	Similar	Identical	Identical	Similar	Identical	Identical	Similar
13	2013 Nov	1st Review	Med-Endocrinology	11/6/2012	3	99213	X			X	10/9/2012	Unique	Similar	None	None	Similar	Similar	Similar
14	2013 Nov	Routine	Anesthesiology	10/23/2012	4	99214	X	X	X		9/25/2012	Identical	Identical	None	Identical	Similar	Similar	Identical
15	2013 Nov	Routine	Anesthesiology	10/25/2012	4	99215	X	X	X		12/8/2011	Unique	Identical	Identical	Identical	Unique	Unique	Unique
16	2013 Nov	Routine	Anesthesiology	10/23/2012	2	99213	X	X	X		10/2/2012	Similar	Unique	None	None	Unique	Unique	Similar
17	2013 Nov	Prospective Review	CT Surgery	11/5/2012	4	99214		X	X		6/20/2012	Similar	Identical	None	None	Identical	Identical	Unique
18	2013 Nov	Readult	Pediatric Endocrinology	11/1/2012	5	99215	X	X	X		1/12/2012	Unique	Identical	None	None	Identical	Identical	Unique
19	2013 Oct	100% Review	MedGI	10/2/2012	8	99214	X	X	X		9/18/2012	Unique	Identical	Identical	Identical	Identical	Identical	Unique
20	2013 Oct	100% Review	MedGI	10/2/2012	7	99214	X	X			7/24/2012	Similar	Similar	Identical	Identical	Similar	Similar	Similar
21	2013 Oct	100% Review	Med-Pulmonary	10/25/2012	2	99235	X	X	X		9/4/2012	Unique	Identical	None	None	Similar	Similar	Unique
22	2013 Nov	100% Review	Med-Pulmonary	10/25/2012	3	99213	X	X			8/24/2012	Unique	Similar	Identical	Identical	Unique	Unique	Unique
23	2013 Nov	Readult	Urology	11/8/2012	5	99213	X			X	10/4/2012	Unique	Unique	Unique	Unique	Unique	Similar	Similar
24	2013 Nov	Readult	Pediatric Neurology	11/8/2012	3	99214	X	X	X		8/1/2012	Identical	Identical	Identical	Identical	Identical	Similar	Similar
25	2013 Oct	Readult	Pediatric Neurology	10/25/2012	3	99214	X	X	X		8/25/2012	Unique	Identical	Identical	Identical	Similar	Identical	Unique
26	2013 Oct	Readult	Pediatric Neurology	10/23/2012	5	99214	X	X	X		9/19/2012	Identical	Identical	Identical	Identical	Identical	Identical	Similar
27	2013 Nov	Routine	Med-Infectious Disease	11/3/2012	2	99232		X	X		11/2/2012	Unique	None	None	None	None	Identical	Identical
28	2013 Nov	Routine	Primary Care	11/8/2012	3	99213	X	X	X	X	10/22/2012	Unique	None	None	Similar	Unique	Unique	Unique
29	2013 Nov	Routine	Primary Care	11/8/2012	6	99213	X	X	X		4/16/2012	Unique	None	None	None	None	Unique	Unique
30	2013 Nov	Routine	Ophthalmology	11/8/2012	4	92014		X	X		3/7/2012	Unique	Identical	Identical	Unique	Unique	Similar	Unique
31	2013 Nov	Routine	Med-Hospitalist	11/15/2012	2	99233		X	X		11/14/2012	Similar	None	None	None	Similar	Unique	Similar
32	2013 Nov	Routine	Med-Hospitalist	11/15/2012	2	99233	X	X			11/14/2012	Similar	None	None	None	Identical	Identical	Similar
33	2013 Oct	Routine	ENT	10/5/2012	2	99212	X	X	X		9/9/2011	Unique	Unique	None	None	Unique	Unique	Unique
34	2013 Oct	Routine	ENT	10/11/2012	3	99215				X	10/5/2012	None	None	None	None	None	None	Unique

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Audit Period	Audit Mode	Case	DOS	HPI	PMH	FH	SH	ROS	Exam	MDM	EM Category
FY2013 May	Prospective Routine	33	5/8/2013	Unique	N/A	N/A	N/A	N/A	Identical	Identical	Office Visit, Established
FY2013 Jun	Prospective Routine	17	6/14/2013	Identical	Identical	Identical	Identical	Identical	Identical	Identical	Office Visit, Established
FY2014 Jul	Prospective Routine	5	7/5/2013	Identical	Identical	N/A	N/A	Unique	Unique	Identical	Inpatient Care, Subsequent
FY2014 Jul	New Provider 1st Review	9	7/8/2013	Identical	Identical	Identical	Identical	Identical	Identical	Identical	Office Visit, Established
FY2014 Jul	Prospective Routine	41	7/7/2013	Unique	N/A	N/A	N/A	Unique	Identical	Identical	Inpatient Care, Subsequent
FY2014 Jul	Prospective Routine	15	7/8/2013	Identical	N/A	N/A	N/A	Unique	Identical	Similar	Inpatient Care, Subsequent
FY2014 Jul	Prospective Routine	24	7/23/2013	Identical	N/A	N/A	N/A	Identical	Identical	Similar	Inpatient Care, Subsequent
FY2014 Jul	Prospective Routine	24	7/23/2013	Identical	N/A	N/A	N/A	Identical	Identical	Similar	Inpatient Care, Subsequent
FY2014 Aug	Re-audit effective 2007_Q4	7	8/6/2013	Unique	Identical	Identical	Identical	Identical	Identical	Identical	Office Visit, Established
FY2013 Apr	Targeted for External Review	19	4/22/2013	Unique	Unique	Similar	Similar	Unique	Identical	Identical	Office Visit, Established
FY2013 Mar	Targeted for External Review	114	3/25/2013	Unique	N/A	N/A	N/A	Unique	Identical	Identical	Office Visit, Established
FY2014 Jul	Prospective Routine	6	7/24/2013	Unique	Identical	Identical	Identical	Identical	Identical	Identical	Office Visit, Established
FY2013 Jun	Prospective Routine	14	6/18/2013	Identical	Similar	Identical	Identical	Identical	Identical	Similar	Office Visit, Established
FY2013 Jun	Prospective Routine	16	6/18/2013	Identical	Identical	Identical	Identical	Identical	Identical	Similar	Office Visit, Established
FY2014 Jul	Prospective Routine	196	7/2/2013	Identical	N/A	N/A	N/A	Identical	Identical	Unique	Inpatient Care, Subsequent
FY2014 Jul	Prospective Routine	195	7/2/2013	Identical	N/A	N/A	N/A	N/A	Identical	Unique	Inpatient Care, Subsequent
FY2014 Jul	Prospective Routine	197	7/2/2013	Identical	N/A	N/A	N/A	N/A	N/A	Identical	Inpatient Care, Subsequent
FY2014 Aug	Prospective Routine	10	8/19/2013	Identical	N/A	N/A	N/A	N/A	Identical	Identical	Office Visit, Established
FY2014 Aug	Prospective Routine	13	8/16/2013	Similar	N/A	N/A	N/A	N/A	Identical	Identical	Office Visit, Established
FY2014 Aug	Prospective Routine	19	8/15/2013	Identical	N/A	N/A	N/A	Unique	Identical	Unique	Inpatient Care, Subsequent
FY2014 Aug	Prospective Routine	19	8/15/2013	Identical	N/A	N/A	N/A	Unique	Identical	Unique	Inpatient Care, Subsequent
FY2014 Aug	New Provider 1st Review	6	8/18/2013	Similar	Identical	N/A	N/A	N/A	Identical	Identical	Inpatient Care, Subsequent
FY2014 Jul	Prospective Routine	1	7/25/2013	Identical	Identical	Identical	Identical	Identical	Identical	Similar	Office Visit, Established
FY2013 Jun	Prospective Routine	40	7/3/2013	Identical	Identical	N/A	Unique	Identical	Identical	Identical	Office Visit, Establish

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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 EHR tools (templates, macros, copy forward functionality)
  - Other documentation rules – time for a refresher
  - Quality Implications
  - Billing Compliance Risks

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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

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To: All Department Chairmen
All Division Chiefs
All Department Compliance Leaders and Liaisons
All Department Administrators

From: Stephen J. Thomas, M.D., Associate Dean, Billing Compliance

Subject: Medical Record Documentation

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 "cloned notes", which is broadly described as excessive identical/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.). CMS has issued the following statement concerning cloned notes: "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."

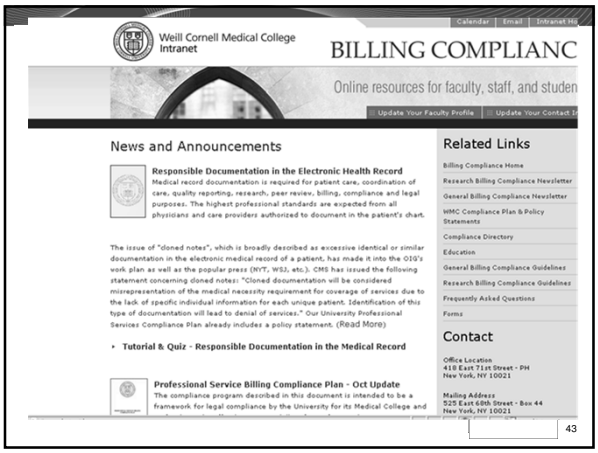
Our University Professional Services Compliance Plan already includes a policy statement entitled "Electronic Medical Record Documentation". It includes guidance for EMR functionality such as copy and paste, cut and paste, copy forward and templates. The policy explicitly states that "*Each note is expected to be an account of the history, exam, medical decision making, counseling, coordination of care and/or procedures performed on the date of service it represents. The content of the current note needs to be specific and pertinent to that day's service(s).*" Recent compliance sample reviews across all departments and providers have identified instances of identical documentation entries in separate visit notes (for the same patient over time).

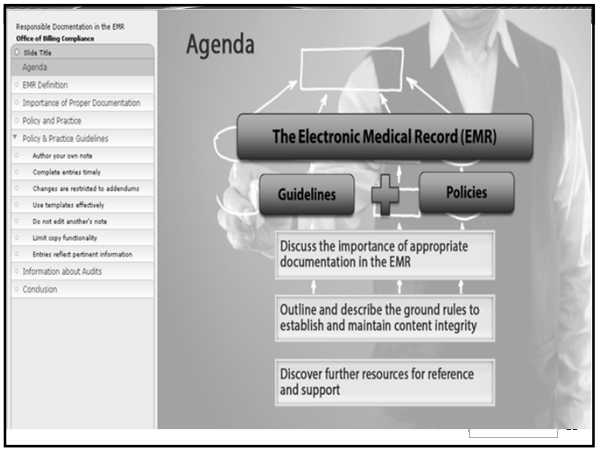
To further explain the issues involved, the Billing Compliance Oversight Committee has developed an on-line tutorial entitled "Responsible Documentation in the Electronic Health Record" and will require this training for all P.O. Faculty. Instructions for the on-line tutorial will be sent to your Departmental Compliance Leader and Liaison.

The Committee also approved an Evaluation and Management service audit work plan that will require notes to be reviewed for "cloning". A note will be considered cloned if two or more key elements are identical. The key elements reviewed will be the (1) history of present illness, (2) the physical exam and, (3) the assessment and plan. As per usual billing compliance policy and procedures, these reviews will be conducted pre-billing and the results will be shared with the provider to resolve any documentation issues identified prior to releasing the bill.

Please distribute this notice to all faculty providers (physicians and non-physician practitioners). Encourage them to review the "Electronic Medical Record Documentation" policy in the University's Professional Services Compliance Plan and to document responsibly and professionally to avoid creating notes that could be deemed cloned.

Questions can be directed to the Office of Billing Compliance at 212-746-0145.





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."

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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."

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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**

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QUESTIONS?

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