Compliance in the Age of EHR

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Electronic Health Records

- EHR - Both a blessing…
  - More efficient
  - Legible
  - Easily accessed remotely
  - Easily transportable
  - Searchable
  - Comparable

Electronic Health Records

- …and a curse
  - Too efficient - Fills in everything
  - Even the nonsense is readable
  - Accessed remotely - by whom?
  - Easily transportable - to whom?
  - Searchable - by whom?
  - Garbage in garbage out

Electronic Health Records

- EHR was supposed to reduce Healthcare Costs but they actually increased 48% from 2001-2010
- What was a 2-page encounter has now ballooned to 5-6 pages

Financial Interest

I acknowledge a financial interest in the subject matter of this presentation.
OIG Target

- **Inappropriate payments for E&M Services**
  - OIG will continue to determine to what extent certain E&M services were inappropriate
  - Will also review multiple E&M services associated with same providers for documentation errors
  - CMS has noticed increase in identical documentation across services
  - Adjusting their review practices
    - Auditing a series of services not just one

DHHS

- **OIG Investigation**
  - “Experts in health information technology caution that EHR technology can make it easier to commit fraud. For example, certain EHR technology features may be used to mask true authorship of the medical record and distort information to inflate health care claims.”
  - “Although EHR technology may make it easier to perpetrate fraud, CMS and its contractors have not adjusted their practices for identifying and investigating fraud in EHRs.”

DHHS

- **OIG Investigation**
  - Estimated cost of Healthcare Fraud $75 - $250 Billion
  - CMS and its Contractors had not “adjusted their practices for identifying and investigating fraud” from paper charts

- **Ways EHRs May Facilitate Fraud**
  - Copy-Pasting – Failing to update, Inflate Claims
  - Over documentation – inserting false or irrelevant documentation to create the appearance of support for billing higher level services.

DHHS

- **Ways EHRs May Safeguard Against Fraud**
  - “Usage policies and technology features, if used consistently, could help prevent EHR fraud. However, providers that use EHR technology can often disable or bypass these features, making them ineffective.”
  - “Audit logs track changes within a record chronologically by capturing data elements, such as date, time, and user stamps, for each update to an EHR. An audit log can be used to analyze historical patterns that can identify data inconsistencies.”

DHHS

- **A minority of CMS contractors reported the ability to identify copied language or over documentation**
  - CMS to provide guidance to its contractors for detecting fraud associated with EHRs
  - CMS to increase the use of audit logs

DHHS

- **Department of Health and Human Services to OIG**
  - “medical record keeping within an EHR deserves special considerations”
  - “the original content, the modified content, and the date and authorship”
Template vs. Macros in EHR

- Templates (compliant) – “pre-loaded frameworks that include history questions asked with individualized documentation of the responses or exam elements to be examined with individualized documentation of the findings.”


Template vs. Macros in EHR

- Macros (non-compliant) – “include the templated question, plus pre-loaded generic negative history responses and normal findings...As automatic or single-click tools, the macro loads a completed clinical document before the patient has even been evaluated.”


Cloned Documentation

- Cloned Documentation
  - Previous visit findings brought forward including typos & misspelling
  - Pre-populating Fields
    - Load exam with pre-programmed findings
  - Causes documentation to look dubious
    - Creates contradictions
    - Was the element actually performed
    - Makes it difficult to code

Cloned Documentation

- Certain Information Never Changes
  - Previous health episode
    - Examples: MI August 2012, Shingles trunk 1999
  - Surgeries
    - Examples: Cardiac Stent 2014, Mastectomy 2011
  - Allergies
    - Examples: P-cillin– Hives, Shellfish – anaphylaxis
  - Family History
    - Examples: Glaucoma – Father, DM – Mother

Cloned Documentation

- Some Information May Not Change
  - Exam Findings
    - Examples: pseudophakia, corneal scar @ 2:00, C:D ratio .35, chorioretinal scar
  - Assessment/Impression
    - Example: Diabetes Type II w/o ophthalmic findings
  - Plan
    - Example: Stress tight Blood Sugar control through diet, exercise and medical follow-up

Cloned Documentation

- Bringing forward is more efficient – BUT
  - Reviewed for accuracy by the provider?
  - Was it medically justified?
  - Relevant to the reason for the patient’s visit?
  - Was it really asked or examined?
  - Did it contribute to the overall treatment?
  - “Speed is not the same as efficiency”
EHR Patient History Issues

- Chief Complaint (CC) & History of Present Illness (HPI)
  - Prompts to document 4 or more
  - Dropdown lists
  - Adding nonsensical HPI
- Patient CC & HPI most important part of the documentation
  - Determines if the service is covered
  - Creates the foundation for exam extent

EHR Patient History Issues

- HPI must be obtained by the rendering provider
  - The provider at the end of the exam - inadequate
  - "Approved" by the provider – inadequate
  - "Dictated by:" and "Scribed by:" - appropriate
    - With identities of each
  - Some EHRs state: "HPI obtained by I. Seemore, M.D."

HPI in E&M Codes

- HPI is the development of current illness since last visit, first sign or symptom
  - Must be taken by rendering physician
- Includes any of following:
  - Associated Signs & Symptoms – (watering with burning, flashes with floaters, nausea with pain)
  - Location (eyes, forehead, eyelids)

HPI in E&M Codes

- Quality (Itching, burning, dryness, tired/stressed, cloudy)
- Severity (Degrees of pain or LOV, adjectives such as very, slight)
- Duration (Date of onset or how long symptoms have been occurring)
- Timing (AM, PM, upon waking, after drops)
- Context (While driving, reading, or other activity)
- Modifying Factors (Actions that result in worsening or improving the symptoms)

HPI in EHR

- Pick Lists are Problematic
  - "Modifying factors: relieved by nothing"
  - "Severity: No pain"
- Creates a nonsense narrative
  - Translates to letter to referring doctor
- Includes NON Pertinent Negatives
History Example #1

- Exudative AMD
- "Pt. states his vision is good, no flashes of bright lights, no blurred vision on OU, no pain, no floaters"
- The EMR counted 4 elements for the HPI
  - Location: OU
  - Quality: blurred, good
  - Associated Symptoms: floaters, flashes, pain
  - Context: bright lights

History Example #2

- Exudative AMD
- "Pt. states no changes in vision OU since last visit. No pain OU. No new floaters or flashes of light OU."
- The EMR counted 5 elements for the HPI
  - Location: OU
  - Quality: new
  - Associated Symptoms: floaters, flashes, pain
  - Timing: last visit
  - Modifying Factors: light

ROS in E&M Codes

- ROS is an inventory of body systems for past or current signs or symptom
  - Can be recorded by the patient or staff member
- CMS has identified 14 organ systems:
  - Allergic/Immunologic (medications, hay fever)
  - Cardiovascular/Cardiac (HBP, palpitations, irregular heart beat, chest pain)
  - Constitutional symptoms (recent fever, weight loss or gain, fatigue)
  - Ears, nose, mouth & throat (tinnitus, chronic post nasal drip, dry mouth)
  - Endocrine (Diabetes, Thyroid Disease)
  - Eyes (loss of peripheral vision, decreased vision, diplopia, pain in eye)
  - Gastrointestinal (ulcers, nausea, appetite good, GERD, constipation)
  - Genitourinary (kidney failure, difficulty urinating, post-menopausal, incontinence)
  - Hematologic/lymphatic (blood thinners, swelling, anemic)
  - Integumentary (lesions, rashes)
  - Musculoskeletal (joint pain, on Plaquenil, Lupus, RA, muscle spasms)
  - Neurological (headaches, dizziness, syncope, paralysis or tremors)
  - Psychiatric (depression, memory loss, hallucinations)
  - Respiratory (SOB, bronchitis, coughing, asthma)
ROS in E&M Codes

- CMS has indicated that a single negative answer for all systems is unacceptable.
- If no positive or pertinent negative responses, at least 10 of the 14 systems must be individually documented.

ROS in EHR

- All Systems Documented on Every Visit
  - Regardless the reason for the encounter
- No Notation the ROS was Updated
  - Brought Forward?
- No Indication the Provider Reviewed
- All Systems are Normal
  - Patient has a host of medical issues

PFSH in E&M Codes

- PFSH is a record of the patient’s experiences in three areas:
  - Past – Previous illness, surgeries, injuries and/or treatments
  - Family – Usually related to ocular diseases, diabetes or hypertension
  - Social – Living arrangements, hobbies, work status, use of drugs, smoking, or alcohol

PSFH in EHR

- All Are Documented as Being Done on Every Visit
  - Regardless the reason for the visit
- Contradictory –
  - “Never a Smoker” “Current–PPD Smoker”

Medications List EHR

- Some EHRs have “Start” and “Stop”
  - “Start” repeated over visits when the patient started it months earlier
  - “Stop” not completed – documented that patient still taking post surgical drops long after surgery
- Dosage mismatched with the “Plan”

Exam Elements in EHR

- All 14 exam elements are filled in on every visit
  - Regardless the reason for the exam
  - Frequency of codes
- Medicare would likely deem this not Medically Necessary unless there is a significant change in the patient’s complaint or condition
# Exam Elements in EHR

<table>
<thead>
<tr>
<th>Implausible Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other documents contradict entries</td>
</tr>
<tr>
<td>CVF=WNL but Automated VF = Large Defect</td>
</tr>
<tr>
<td>Minor self healing conditions continue</td>
</tr>
<tr>
<td>SCH for months</td>
</tr>
<tr>
<td>Chronic conditions disappear w/o intervention</td>
</tr>
<tr>
<td>Lids=WNL but long Hx of Dermatochalasis &amp; Ptosis</td>
</tr>
<tr>
<td>Nonsensical findings</td>
</tr>
<tr>
<td>Pseudophakia but “clear” nucleus &amp; cortex</td>
</tr>
</tbody>
</table>

# Identical Disease Across Patients

- Example: Extended ophthalmoscopy- all retinal disease is the same
  - Edema
  - PVD
  - Hemorrhage
  - Floater
- Fill in the fundus exam

# Assessment in EHR

- Failure to update the Assessment
  - Diagnoses remain “new” despite previously being diagnosed
  - Diagnoses are all listed despite the reason for the visit in the same order
  - Diagnoses are listed that are no longer valid

# Plan in EHR

- The exact same plan from visit to visit
  - Regardless of the reason for the visit
  - “Canned” plans that are all inclusive
  - e.g., cataract is visually significant & interfering with patient’s visual function. [sic] plan lens calculations [sic] & cataract surgery. May need to employ Malyugin ring, Trypan blue, or iris hooks.

# Scanned Documents in EHR

- Patient Registration Paperwork Incomplete
  - Assignment of Medicare Benefits
    - Designated spots left blank
      - Signatures
      - Printed names
      - Dates
  - Privacy Notice
    - Designated spots left blank
      - Signatures
      - Printed names
      - Dates
- Inconsistently filed
  - From patient to patient
  - Within a single patient record
  - Smeared or cut-off copies
  - Large stacks in one scan
  - Missing documents
    - Co-management correspondence
    - Operative notes
Meaningful Use in EHR

- Contradictory notations
  - “Patient never a smoker”
  - “Patient counseled on tobacco cessation”
- Review of Systems
  - “All systems normal”
  - A list of 16 medications is included
    - None for diabetes
    - “Patient counseled on need for blood glucose control”

Diagnostic Tests in EHR

- Orders missing or incomplete
  - Written on fee ticket
  - Only a checkbox
    - No date planned, eye marked, type of test, etc.
- Interpretations missing or incomplete
  - Not separate from assessment or plan
  - Bundled together
    - e.g., fundus photos & fluorescein angiogram

Automated Coding in EHR

- Established Patient
  - Filling in all elements of the History
    - HPI, ROS, PSFH
  - Filling in all elements of the Exam
    - Plus mental status
- EMR will recommend 99215
  - Or 99222 in one EHR

Example #1

- EP – C/O Cloudy vision
- VA – OD: 20/40 OS: 20/30
- Slit Lamp Exam:
  - Lens - OD: Normal Capsule, Nucleus, Cortex
  - OS: Normal Capsule, Nucleus, Cortex
- Assessment: Pseudophakia Visually Significant PCO OU
- Plan: YAG Capsulotomy OD 1st

Example #2

- NP – CEE & HVF billed
- VA – OD: NLP OS: 20/HM
- CVF – OD: Full OS: Full
- EOM: Full
- Pupils – PERRLA – No APD
- SLE – Iris OD: pupil surgically fixed @ 5mm
- Diagnosis: vitreous hemorrhage OS
  - (later developed painful ulcer OD)
- HVF: Near total loss
- Findings repeated over 13 visits over 12 mos by 2 doctors

Example #3

- EP – 2 wk flup blepharitis
- VA – OD: 20/20 OS: 20/20
- CVF - OD: Full OS: 20/20
- EOM - Ortho
- Lids - Normal for age
- Fundus Exam
  - Cup to Disc: . (no that is not a typo on the slide...just a dot)
  - Optic disc: no edema, no neovascularization, good color
  - Vitreous: clear
  - Macula: normal contour and foveal reflex for age
  - Vessels: 2/3 ratio of arterioles/venules w/o tortuosity or abnormality
  - Periphery: flat and attached 360 (indirect ophthalmoscopy)
Example #4

- NP Work-in C/O Foreign Body Sensation OD
- VA – OD: 20/50 (photophobic) tearing 20/20
- Slit Lamp Exam: Lids, lashes, conjunctiva cornea normal OU
- Assessment: corneal foreign body
- Plan: conjunctival foreign body removed

CMS EHR Toolkit

- “Program Integrity: Electronic Health Records” Published in 2015 –
  - What CMS considers important regulatory guidance associated with EHR
  - Intended to address deficiency of certification
  - [www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/electronic-health-records.html](http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/electronic-health-records.html)

Summary

- Do not “Copy-Paste” exam information
  - Especially “Whole Notes”
- Only Document What Was Done
  - As Medically Necessary
- Review Documentation Prior to Closing
  - Accuracy, Provider Requirements

Remember!

- The Medical Record is the Foundation for Proper Billing
  - Would it hold up in post-payment review?
- But More Importantly... It is a LEGAL DOCUMENT!
  - Would it Defend you in Court?

Questions