EMR Documentation and Compliance: The Retina Point of View

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Financial Disclosure

• William T. Koch, COA, COE, CPC
• Advisory Boards
  • Allergan
  • Genentech
  • Regeneron
• Speaker Bureaus
  • Allergan
  • Genentech

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• Financial interest in the material
Objectives

- Compliance issues
- Scrutiny
- Paper vs. EMR
- EMR Documentation
  - Auto populate features
  - Copy and paste
  - Documentation cloning
- ICD-10
- Diagnostic testing

Compliance

Medicare Program Integrity

*The primary principle of Program Integrity (PI) is to protect the Medicare Trust Fund from fraud, waste and abuse. In order to meet this goal, contractors must ensure that they pay the right amount for covered and correctly coded services rendered to eligible beneficiaries by legitimate providers.*

Source: Medicare Program Integrity Manual, Chapter 1 §1.1
OIG Compliance Guidance

An ongoing evaluation process is important to a successful compliance program. This ongoing evaluation includes not only whether the physician practice’s standards and procedures are in fact current and accurate, but also whether the compliance program is working, i.e., whether individuals are properly carrying out their responsibilities and claims are submitted appropriately.

OIG Compliance Program for Individual and Small Group Physician Practices

Who’s Watching

- Office of Inspector General (OIG)
- Comprehensive Error Rate Testing (CERT)
- Recovery Auditor (RA) aka Recovery Audit Contractors (RAC)
- Medicare Secondary Payer Recovery Contractor (MSPRC)
- Zone Program Integrity Contractors (ZPIC)
- Program Safeguard Contractors (PSC)

Target of Scrutiny

E/M: Potentially inappropriate payments

“We will determine the extent to which CMS made potentially inappropriate payments for E/M services in 2010 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 on the basis of the content of the service and have documentation to support the level of service reported.”

Source: HHS OIG FY 2013 Work Plan
Amending Chart Notes

- Cannot “alter” documentation
- OK to amend record
  - Clearly state as amendment
  - Record date of amendment
  - Electronic tracking
  - Audit trail

Amendments, Corrections and Delayed Entries in Medical Documentation

B. Recordkeeping Principles

Regardless of whether a documentation submission originates from a paper record or an electronic health record, documents submitted to MACs, CERT, Recovery Auditors, and ZPICs containing amendments, corrections or addenda must:
1. Clearly and permanently identify any amendment, correction or delayed entry as such, and
2. Clearly indicate the date and author of any amendment, correction or delayed entry, and
3. Not delete but instead clearly identify all original content


Best Practices
Editing / Amending

- Discuss editing and amending process with EMR vendor
- Develop policies and procedures on how to edit and amend a patient encounter
Signature Requirements

- Paper
- Chart request
- Wet signature
- EMR
  - Electronic signature
  - Record locking

Signature Guidelines

“For medical review purposes, Medicare requires that services provided/ordered be authenticated by the author. The method used shall be a handwritten or an electronic signature. Stamp signatures are not acceptable.”

“Providers using electronic systems need to recognize that there is a potential for misuse or abuse with alternate signature methods. For example, providers need a system and software products which are protected against modification, etc., and should apply administrative procedures which are adequate and correspond to recognized standards and laws. The individual whose name is on the alternate signature method and the provider bears the responsibility for the authenticity of the information being attested to. Physicians are encouraged to check with their attorneys and malpractice insurers in regard to the use of alternative signature methods.”

Source: CMS Transmittal 327, March 16, 2010

Best Practices

Log-in / Log-out

- Assign unique log-in for each staff member and physician(s)
- Finger print readers
- ID cards
- PIN
- Password
- Do not permit “sharing” passwords
- Limit access by user type or group
- Develop policies and procedures for opening and closing medical records
Audit Trail

- EMR embeds a computer data trail for each key stroke
  - What?
  - Who did it?
  - When?
- Management should make use of this feature during audits and education of physicians and staff

Paper vs. EMR

- Paper
  - Non EMR offices
  - Not always enough documentation
- EMR
  - Retina specific documentation
  - Too much documentation
Paper Challenges

- Weak or no Chief Complaint
- Limited History of Present Illness (HPI)
- Missing exam elements
- Weak or missing test interpretations
- Physician signature

EMR Documentation

"Garbage in....Garbage out"

EMR Challenges

- Too much documentation “note bloat”
- Billing higher level exams
- Contradictory or erroneous entries
- Missing test interpretations
- Missing procedure notes
- Physician not reviewing final chart
- Electronic signature
- Log-in and Log-out practices
E/M Coding

- Questionable Click and Code practices
- You may document at this level
- However!
- Medical necessity drives level of service
- Limited or lack of EMR documentation to support higher exam levels

New Emphasis on MDM

- Some private payers are putting more emphasis on Medical Decision Making (MDM)
- MDM depends on diagnoses, tests, and management/treatment
- “Note bloat” may be a cause of code inflation if not carefully evaluated for relevancy
- MDM is a critical factor to determine level of service

Example

- 99204 New Patient Level 4 E/M Code
  - Comprehensive history
  - Comprehensive examination
  - Moderate Level of Medical Decision Making
  - Management of multiple diagnosis with associated risk
  - Elective major surgery
  - Macula off retinal detachment
  - ERM

1997 Evaluation and Management Guidelines
Example
- 99205 New Patient Level 5 E/M Code
  - Comprehensive history
  - Comprehensive examination
  - High level of Medical Decision Making
  - Emergent major surgery
  - Macula on retinal detachment
  - Endophthalmitis
  - Same or next day surgery

1997 Evaluation and Management Guidelines

E/M Coding
- 99215 Established Patient Level 5 E/M Code
  - Comprehensive history
  - Comprehensive examination
  - Medical decision making of high complexity
  - 2 of 3 required
  - Recurrent detachment
  - Endophthalmitis

Source: CPT Manual

RAC Audits of E/M Services
- EHR users increase utilization of 99214, 99215 because physicians are able to document better
- RAC audits of these codes based on HHS OIG report – Coding Trends of Medicare Evaluation and Management Services, May 2012
- OIG states: “Although many EHR systems can assist physicians in assigning codes for E/M services, we found that most Medicare physicians manually assigned E/M codes.”
Case – Impression & Plan

• Dry AMD OU, stable, plan to observe

What level of MDM applies?

Case – MDM Dx

• Dry AMD OU, stable • 1 Point

Case – MDM Tests

• Review, order medical test (OCT) • 1 Point
### Case – MDM Risk

- Problems: 1 stable chronic illness
- Dat/Tests: OCT
- Management: observe
- Low
- Minimal

### Decision Making

**2 of 3 Key Components**

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### New Patient Office Visit

**3 of 3 Key Components**

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Established Patient Office Visits
2 of 3 Key Components

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Eye Codes

- Another possible Click and Code challenge
- Comprehensive Eye Code 92014
  - External Exam (Adnexa)
  - Gross Visual Fields (CVF)
  - Basic Sensorimotor Exam (Motility)
  - Ophthalmoscopic Exam (Fundus)
- Always includes initiation of a diagnostic and treatment program

Source: CPT Manual, Ophthalmology, Coding Rules
Scribes

- Busy clinic
- Physician relies on scribe
- Holes in documentation
- Review all documentation before data is locked
- Attestation statement in record when using a scribe

Case Study

- Chief Complaint:
  - “Patient reports having cataract surgery in the right eye back in October.”
- Ocular History:
  - Eye Surgeries: 10/03/13 CE
- Physician Exam:
  - OD Lens Trace NS
- Assessment
  - Cataract / bilateral, Unchanged

Auto Populating

- Copy and paste
- Pull forward
- More efficient use of time?
  - Same Chief Complaint for multiple visits
  - Same diagnosis
  - Same impression and plan
Problems with Copy and Paste

- Integrity of record questioned – misrepresentation
- Confusion from nonsensical language
- Note bloat
- Difficulty identifying relevant information
- HIPAA violation where information copied from one patient record to another
- Copying prior records that contain errors
- Potential patient care issues
- Possible malpractice concerns

Case Study

- Patient presented with decreased vision both eyes
- Initial exam diagnoses
  - Proliferative diabetic retinopathy
  - Diabetic vitreous hemorrhage
  - Retinal detachment
- Vitrectomy for diabetic vitreous hemorrhage
- No retinal detachment
- Retinal detachment became primary diagnosis
- Wrong diagnosis changed 1 year later

Billing

- Level of service
- Modifier errors
- Injections
  - Unilateral vs. bilateral injections
- Wrong diagnosis
- Too many diagnoses
- Diagnosis no longer apply
Case Study

- 2 Aflibercept (EYLEA) injections performed
- Diagnosis of BRVO carried over from previous exam
- Overlooked by multiple staff members
- 1st injection denied
- Discovered error after 2nd injection was done
- Confirmed diagnosis should have been CRVO

EMR and HIPAA Issues

- Celebrities – patient confidentiality
- Controlled access to PHI by staff
- Breaches – failure to keep PHI protected
- HIPAA compliant computer screens
- Patient access to data
- Business Associate Agreement (BAA) for vendors
- Log-in protocol
- Log-in time out protocol

EMR and HIPAA Issues

- Data always looks real even if it isn’t
- Charting by default can hide medical problems
- Copy forward can produce legacy data not relevant to current date of service
- Quantity of information increases
- Information overload
HPI Challenges

They told me:
“I MUST GET 4 HPI ELEMENTS”
• Location
• Duration
• Timing
• Quality
• Severity
• Context
• Modifying factors
• Associated signs and symptoms

HPI Challenges

CC: Patient is newly diagnosed diabetic
• Location: OU
• Duration: 3 months
• Timing: Constant
• Quality: Fixed
• Severity: Vision not affected
• Context: -
• Modifying factors: Driving at night
• Associated signs and symptoms: None

Success!!! – “I GOT 7”

HPI EMR “hic-ups”

THE FINAL PRODUCT:
• 58 year old male presented for evaluation of Diabetes for 3 months. Vision not affected. The problem is constant. It occurs primarily when driving at night. Quality is fixed. Patient described the following signs and symptoms: none currently to report.

• Not our best effort.
EMR Hiccups

- 66 year old male complains of blur at near in both eyes. The timing is described as all the time. Quality is unchanging. Context is reported without glasses.
- 78 year old female presented for evaluation of existing condition, DIABETES in systemic since 1991. The timing is described as all the time. Quality the BSL runs high. Relief is experienced from takes medication.
- 53 year old female complains of growth in left eye for 1 year. The timing is described as constant.

ICD-10

- Open communications with computer vendor
- Open communications with clearinghouse
- End-to-End Testing
- Medicare
- Private payers
- Protocol for diagnosis code selection by staff
- Adhere exclusively to ICD-10 descriptions to avoid confusion and redundant code selection
ICD-10

- Medical
- Higher specificity
- Coding
- Billing
- Political
  - Adoption has been delayed multiple times
  - Recent delay due to Act of Congress
  - Tied to Sustainable Growth Rate (SGR) patch
  - New implementation date October 1, 2015

Code Expansion

- ICD - 9
  - 3 to 5 digits
- ICD - 10
  - 3 to 7 digits
  - 14,000 to 68,000 codes
  - Higher specificity
  - More documentation

Code Structure Variability

- Age-Related Macular Degeneration (AMD)
  - No laterality
  - Nonexudative AMD
    - ICD - 9 = 362.51
    - ICD - 10 = H35.31
  - Exudative AMD
    - ICD - 9 = 362.52
    - ICD - 10 = H35.32
Code Structure Variability

- Laterality
  - Right eye vs. Left eye
  - No laterality
- Combination codes
  - Diabetes Mellitus
  - No laterality

W22.02XD Walked into lamppost, subsequent encounter

Diagnostic Testing

Test Interpretation

- Requirements are the same
  - What does it show?
    - Increased edema RT macula from last OCT
  - What does it mean?
    - Worsening edema / wet AMD
  - What are you going to do about it?
    - Anti-VEGF injection
Extended Ophthalmoscopy

Tear

Drusen

Summary

• Review compliance policies related to EMR
• Code based on medical necessity
• Limit copy / paste and auto populating
• Review EMR documentation for errors
• Review EMR for missing documentation
• Review internal HIPAA policies related to EMR
• Physician information should be entered when physician is logged in
• Prepare for ICD-10 documentation challenges
• EMR is here to stay

More help...

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