Electronic Health Records: Issues, Concerns, and Best Practices

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Outline
1. EMR documentation is different
2. Use of free text
3. Open vs. closed records
4. Changes to EMR records
5. HIPAA concerns
6. Threats to EMR data/Compliance Issues
7. Payer documentation issues
8. Best practices

EMR is Different!
• Fixed data fields
  • Encouraged to use but may not match a pt’s history needs well
  • Can you / should you customize?
• Free texting
  • When or IF?

Fixed Data Fields
• Searchable data
• Wide variety of choices
  • Drop-down menus common
  • Editable for practice style/verbiage?
• History taking
  • Chief Complaint (CC), History of Present Illness (HPI)
  • Review of Systems (ROS) and Personal Family Social History (PFSH)
• Impression and Plan “Templatting”

History
History of Present Illness
• History of Present Illness (HPI)
  • Location
  • Quality
  • Severity
  • Modifying factors
  • Timing
  • Context
  • Duration
  • Associated signs and symptoms
**History Taking**

- **HPI concerns**
  - Constant use of drop downs with poor fit
  - No attestation of physician performance via EMR
- **Examples of HPI element issues:**
  - Pseudophakia constantly all the time for 1 year
  - 53 year old female complains of no growth of left eye for 1 year. The timing is described as constant. The quality is unchanging. There is no pain.
  - 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 from drops.
- When should pertinent negatives count?

**Review of Systems**

- The charts ALL appear fantastic here!
  - But … “Do you believe it?”
- **ROS concerns**
  - Cloning
  - Copy forward
  - Be sure to alter things when they are different
- **Best Practices**
  - Don’t ask “Is anything changed?”
  - Who has perfect recall?
  - Better: “Your charts shows XXYY. Is that correct?”

**The Case for Copy-Paste**

- EHRs allow better and more complete documentation
  - “I was already doing it, now my charts show it”
- Generating more accurate claims
  - Better documents = accurate charts = proper payment
- Meet growing demands for efficiency
  - Constant pressure to see more people
  - Decreasing per visit revenues
  - Efficient use of technology
  - Searchable data

**Problems from Copy-Paste**

- Integrity of record can be questioned – is there misrepresentation?
- Confusion from nonsensical language
- “Note bloat” (Information overload)
- HIPAA violations
  - Information copied from one pt record to another pt
  - Copying old records (same pt) that already have errors
  - Potential patient care and malpractice concerns

**Problems from Copy-Paste**

- Voluntary survey 864 hospitals:
  - Nearly all had capability for recommended audit functionality
  - Only 24% had a written policy on cut-and-paste
  - Of those w/ a policy:
    - 61% shifted the responsibility to the EHR user on any copied-pasted data & its accuracy
    - 44% of the “audit log” systems could record whether cut-and-paste was used
    - 44% can delete their internal audit logs whenever they’d like

**Living with Copy-Paste**

- Minimize use
- Employ alternative approaches
  - Drop down menus
  - Pick lists
- Edit copied notations with new information
- Verify every copied notation and click it
- Have a written policy, stick to it!
Target for Scrutiny
E/M: Potentially Inappropriate Payments

“We will assess the extent to which CMS made potentially inappropriate payments …
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 … based upon … the service and … documentation to support [it].”

Source: HHS OIG FY 2012 Work Plan

Free Text

• When to consider
  • No other good option in EMR
  • Drop-down wrong or inappropriate
  • Will it show up to provider?

• When to avoid it
  • Already a drop-down that meets condition
  • May not show on tech or nurse screen
    • Communicate the information somehow to provider

HIPAA Top 6 Breach Sources

<table>
<thead>
<tr>
<th>Breach Location</th>
<th>% of Breaches</th>
<th>% of Records</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laptops</td>
<td>25%</td>
<td>12%</td>
</tr>
<tr>
<td>Paper Records</td>
<td>24%</td>
<td>4%</td>
</tr>
<tr>
<td>Mobile Media</td>
<td>16%</td>
<td>51%</td>
</tr>
<tr>
<td>Desktop Computers</td>
<td>11%</td>
<td>8%</td>
</tr>
<tr>
<td>Network Server</td>
<td>9%</td>
<td>17%</td>
</tr>
<tr>
<td>System Application</td>
<td>5%</td>
<td>5%</td>
</tr>
</tbody>
</table>

Source: Analysis of US Healthcare breach data. Health Information Trust Alliance (HITRUST), 2012

Security Threats

• Threat – the potential for a person or thing to exercise (accidentally trigger or intentionally exploit) a specific vulnerability
  • Natural threats
  • Human threats
  • Environmental threats

Natural Threats

• Flood
• Earthquake
• Tornado
• Landslide

Human Threats

• Network attack
• Malicious software upload
• Unauthorized access
• Inadvertent data entry
• Accidental deletion
• Unintended action
Environmental Threats

- Power failure
- Pollution
- Chemical or liquid leakage (e.g., broken water line)

HIM Compliance Issues

- How long can a medical record remain open and unsigned?
- What reason(s) justifies keeping a record open?
- How is a closed record changed?
- What are your HIM policies? Is there a policy?
- Does management track & record alteration and if there are open records?
- Control over logon and screen viewing?
- Periodic password change demand?
  - Password strength?

Paper Records

- Use a single-line strike-through of the original documentation
- Date it
- Sign it

EMR is not so simple!

- Addenda
- Amendments
- Corrections
- Deletions
- Late entries
- Retractions

Addendums

- Addendum – new documentation used to add information to an original entry (e.g., late info)
- Separate notation from the original
- Includes reason for adding information
- Current date
- Signed by provider
- If applicable, forward to other care givers who received the original note

Amendments

- Amendment – a note meant to clarify information within a health record
- Standout notation within the record
- Current date
- A second signature
- Authority to “unlock” a record must be restricted
Corrections

- Correction – a change in the information to fix inaccuracies in the original health record
- Standout notation within the record
- Current date
- A second signature
- Authority to “unlock” a record must be restricted

Deletions

- Deletion – removing information without substituting new information
- Not recommended

Late Entries

- Late Entries – information entered into the health record after the point of care
- Standout notation within the record
- Current date
- A second signature
- Authority to “unlock” a record must be restricted

Retractions

- Retraction – correcting information that was incorrect, invalid, or made in error by preventing display or hiding it from future general view
- Incorrect information is available in background, but will not display in the regular record view or be released upon request for record.
- Authority to “change” a record must be restricted

Audit Trail

- EHR 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

Altering Medical Records

- A world of trouble…
  - Professional liability insurer could cancel coverage
  - Possible criminal charges for fraud or perjury
  - Might lose your medical license.
  - Alteration might be viewed as professional misconduct

Source: Medical Economics, June 6, 2003
Payer Concerns about EMR

- Copy forward and cloning notes
- “All other systems negative”
  - Some payers allow but many do not
- EMR that allow single click for “no change”, then all populate from prior
  - Perhaps not “all” were really done
- Are all elements pertinent to the treatment of the condition?
- Up-coding and believability
- Test interpretations

RAC Audits of E/M Services

- EHR users may increase utilization of 99214/5
  - Documentation is better now
  - Payers are watching utilization closely
- RAC audits of these codes based on HHS OIG report – Coding Trends of Medicare Evaluation and Management Services, May 2012
  - Palmetto did random prepayment audits of 99214/5 (CA/NV/HI, varies by specialty and location)
  - FL pre-payment audit of all 99215 for OD’s
- OIG states: “Although many EHR systems can assist … in assigning codes … most physicians manually assigned E/M codes.” (Yay!)

Diagnostic Tests and EMR

- Eye care involves lots of tests
- Payer focus on orders and interpretations
  - EMR has special considerations
  - Who/What/When recording

Diagnostic Test Orders

- Tests are ordered for a medically appropriate reason
  - Technicians cannot order tests
- Order may be scribed by staff on physician’s direction
  - “VF for COAG next visit per Dr. Smith”
- Standing orders pose challenges.
  - They may be screening and not covered. When not individualized, they might not be reimbursed.

Interpretation & Report

Carriers generally distinguish between an ‘interpretation and report’ of an x-ray or an EKG procedure and a ‘review’ of the procedure. A professional component billing based on a review … without a … written report similar to that which would be prepared by a specialist … does not meet the conditions for … payment of the service … [since] the review is already included in the payment.

An ‘interpretation and report’ should address … findings, relevant clinical issues, and comparative data …“

Source: CMS MCPM Chapter 13, §100

Chart Documentation Diagnostic Test Review

- Get a specific order for each patient
  - Record the order in EMR before test is performed
- Do the test, record your part, make the handoff
- Send the test via EMR to physician inbox in EMR
- MD opens test and does interpretation
  - EMR note closed and EMR system records the closure

Now the test can be billed in full; it has a proper up-to-date diagnosis!
Best Practices

• Limit Copy-Paste
• Pay attention to EMR security
  • Physical and People Issues
  • Have a Security Assessment, review at least annually
• Track code utilization by provider
• Control logon, regular & strong password change
• Watch EMR record changes, have an Audit trail
• Diagnostic test issues

More help…

For additional assistance or confidential consultation, please contact us at:

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