Achieving Meaningful Use with Compliant Documentation

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Financial Disclosure

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The instructor has a financial interest in the subject matter.

Financial Disclosure

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The instructor has a financial interest in the subject matter.
MUS1 vs. MUS2

- EHR vendors have to support both and you will need to maintain proficiency for both
  - Every EP gets at least two years at Stage 1
  - Every EP gets at least two years at Stage 2
- 2011 Certification expired on 12/31/13 for ALL vendors
- 2014 Certification covers Stage 1 and Stage 2

MUS1 vs. MUS2

- From 13 to 17 Core Measures
  - Only two brand new measures
  - %’s increased
  - Menu Set measures “blended” into Core
  - Clinical Summaries (CCDA) expanded

MUS1 vs. MUS2

- From 13 to 17 Core Measures
  - CPOE
    - Recorded by “certified staff”
    - Scribe certification: http://theacmss.org/
  - Radiology Orders - Order for any imaging services that uses electronic product radiation. The EP can include orders for other types of imaging services that do not rely on electronic product radiation in this definition as long the policy is consistent across all patient and for the entire EHR reporting period.
  - Electronic product Radiation - Any ionizing or nonionizing electromagnetic or particulate radiation, or [a]ny sonic, infrasonic, or ultrasonic wave that is emitted from an electronic product as the result of the operation of an electronic circuit in such product.
**MUS1 vs. MUS2**

- From 5 of 10 Menu Set Measures to 3 of 6
  - Many MUS1 Menu Set measures “blended” into MUS2 Core Measures
  - One old Menu Set and five new Menu Set measures
  - Exclusions no longer count (unless you can exclude all 6 of them)

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**EHR Documentation Issues**

“Garbage in . . . Garbage out”

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**Why you should be concerned**

- EMR will not solve current documentation problems
  - It may spread the problems faster/farther
  - Improve legibility (obviously)
  - Does it look to good?
  - Blanks are ok – how did you document with paper?
EHR Audits

- CMS has hired a CPA firm to audit individual clinicians and hospitals who attested
- Letter requests 4 types of documentation
  1. EHR is certified
  2. ER admissions
  3. Claims satisfied MU objectives and measures
  4. Claims satisfied voluntary MU objectives and measures
- Documentation to be sent within two weeks of request
- Figliozzi and Company – Accounting firm in Garden City, NJ


EHR Bonus Audits

- What happens if I fail the MU audit?
  - Not eligible for payment (prepayment review in future MU payment years)
  - Recoupment of EHR MU Payment (post payment review)


MU Audit Letter
MU Audit

Letter

MU Audit

- Pre-payment
- Post-payment

MU Audit – 1st Round

<table>
<thead>
<tr>
<th>Item Number</th>
<th>Initial Request Date</th>
<th>2nd Request Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>a.</td>
<td></td>
</tr>
</tbody>
</table>
| 2           | Please list each office or other outpatient facility where you see patients and indicate whether or not you utilize Certified Electronic Health Record Technology. 
|             | At how many offices or other outpatient facilities do you see your patients? |
| 3           | Please provide a response to the following questions: b. |
|             | Centers for Medicare and Medicaid Services Document Request List - Eligible Professionals |
|             | Medicare Electronic Health Record (EHR) Incentive Program |

PART I - GENERAL INFORMATION

Eligible Professional:

REQUESTED DOCUMENTS

Please provide all of the documents requested below by the due date. The auditor will complete Column C.

As proof of possession of a Certified Electronic Health Record Technology system, provide a copy of your licensing agreement with the vendor or invoices. Please ensure that the licensing agreements or invoices are for the product and version of the Certified Electronic Health Record Technology system utilized during your attestation period.

EHR Certification Number:

EHR Reporting Period:

Requested Documents

Yes

No

1. 
2. 
3. 

Provide the supporting documentation (in either paper or electronic format) used in the completion of the Attestation Module responses (i.e. a report from your EHR system that ties to your attestation).

Please Note: If you are providing a summary report from your EHR system as support for your numerators/denominators, please ensure that we can identify that the report has actually been generated by your EHR (i.e. your EHR logo is displayed on the report, or step by step screenshots which demonstrate how the report is generated by your EHR are provided.) To support Y/N attestation measures, please supply documentation such as screenshots from your EHR system.

If yes, please supply documentation which proves that more than 80% of the medical records of unique patients seen during the attestation period are maintained in a CEHRT system at each office or other outpatient facility where a CEHRT system is being used.

Utilize CEHRT?

If you utilize more than one office or other outpatient facility, could you please supply documentation which proves that 50% or more of your patient encounters during the EHR reporting period have been seen in offices or outpatient facilities where you utilize a CEHRT system?

Do you maintain any patient medical records outside of your CEHRT system?
MU Audit – 1st Round

- Proof of possession of a CEHRT - copy of your licensing agreement with the vendor or invoices. Please ensure that the licensing agreements or invoices are for the product and version of the CEHRT.

MU Audit – 1st Round

- Use CEHRT at more than one office?
  - Documentation to prove 50% of encounters were entered in CEHRT.
  - Proof that more than 80% of the medical records of unique patients seen during the attestation period are maintained in a CEHRT system.

MU Audit – 1st Round

- Core Set Measure Attestation Proof
- Menu Set Measure Attestation Proof
### MU Audit – 2nd Round

- Request for daily schedule during reporting period
- Prove 80% of Unique patients
- Documentation to support Yes/No measures
- Proof that attestation report was generated by CEHRT
- Explain variance between documentation and attestation

### MU Audit – 2nd Round

- Exact questions vary depending on your responses to the first round and the documentation provided.

### Audit Concerns

- Copy of report from CEHRT that was used to attest
Audit Concerns

- Evidence to support measures that aren't "counted" (i.e., don't have a denominator and numerator
  - Medication Contraindication warnings
  - Drug Formularies
  - Tests of capabilities to share data electronically and generate report
- SAVE EVIDENCE!

What is Clinical Decision Support (CDS)?

- A rules-based engine that “fires” at some point, automatically or on demand
  - Rules that will assist in providing better care
  - Reduce patients lost to follow up
  - Monitor standard of care
- What auditors are looking for:
  - Screen shots from the software showing that at least one rule was “on” for the duration of the reporting period

CDS for MUS1 vs MUS2

<table>
<thead>
<tr>
<th>MUS1</th>
<th>MUS2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Core Measure 11</td>
<td>Core Measure 6 of 17</td>
</tr>
<tr>
<td>Implement 1 CDS rule</td>
<td>Implement 5 CDS rules</td>
</tr>
<tr>
<td>No restrictions</td>
<td>5 CDS related to 4 or more CQMs</td>
</tr>
</tbody>
</table>
Clinical Decision Support (CDS)

MUS1 Core Measure 11
- Implement 1 CDS Rule (you create)
  - Use them to help improve quality of care and efficiency
  - Annual dilated exam for all diabetics
  - Build protocol for glaucoma patients to insure proper frequency of diagnostic testing
  - Prompt for complete documentation of BCVA, ADLS, etc... prior to cataract surgery

Clinical Decision Support (CDS)

MUS2 Core Measure 6 of 17
- Implement 5 CDS related to 4 or more CQMs
  - NQF 0055 – Diabetic Eye Exam - annual
  - NQF 0088 – Diabetic Retinopathy (+/- ME, Retinopathy Severity) – annual
  - NQF 0089 – Diabetic Retinopathy Communication with primary diabetic physician – annual
  - NQF 0086 – POAG optic nerve exam – annual

Clinical Decision Support (CDS)

MUS2 Core Measure 6 of 17
- Implement 5 CDS related to 4 or more CQMs (cont)
  - NQF 0564 – Cataract surgery complications within 30 days requiring additional procedures
  - NQF 0565 – Cataract surgery patients with 20/40 or better vision within 90 days of surgery

OIG Target for Scrutiny
E/M: Potentially Inappropriate Payments

“We will assess the extent to which CMS made potentially inappropriate payments for E/M services 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 based upon the content of the service and have documentation to support the level of service reported.”

Source: HHS OIG FY 2012 Work Plan

Best Practices
Log in / Log out

- Assign unique log in for each staff member and physician(s)
- Do not permit “sharing” passwords
- Determine what areas of EMR can be accessed by whom
- Develop policies and procedures for opening and closing medical records


EHR Compliance Tips

- Using a scribe
  - Physician should be logged in
  - Documentation must reflect physician work
  - Scribing is “taking dictation”
  - EHR should reflect the use and identity of scribe
    - “Susie Scribe acting as scribe for Dr. I.C. Better”
  - EHR should reflect that physician reviewed information for accuracy.
    - “I agree the documentation is accurate and complete”

www.palmettogba.com/palmetto/providers.nsf/DocsCat/Providers~Jurisdiction%201~Part%20B~CERT~Documentation~8EEL8V4524?open&navmenu=%7C%7C
**Paper Records**
- Use a single-line strike-through of the original documentation
- Date it
- Sign it

**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

**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 caregivers who received the original note
Audit Concerns – Security Risk Analysis

- EHR Incentive / Meaningful Use Core Measure
  - **Objective**: Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities.
  - **Measure**: Conduct or review a security risk analysis of the certified EHR technology, and implement security updates and correct identified security deficiencies as part of its risk management process.
  - **Exclusion**: NONE

As required by The HITECH Act, the OCR issued final “Guidance on Risk Analysis Requirements under the HIPAA Security Rule”: Conducting a risk analysis is the first step in identifying and implementing safeguards that comply with and carry out the standards and implementation specifications in the Security Rule. Therefore, a risk analysis is foundational, and must be understood in detail before OCR can issue meaningful guidance that specifically addresses safeguards and technologies that will best protect electronic health information.

The guidance is not intended to provide a one-size-fits-all blueprint for compliance with the risk analysis requirement. Rather, it clarifies the expectations of the Department for organizations working to meet these requirements. An organization should determine the most appropriate way to achieve compliance, taking into account the characteristics of the organization and its environment.

The Security Management Process standard in the Security Rule requires organizations to “implement policies and procedures to prevent, detect, contain, and correct security violations.” (45 C.F.R. § 164.308(a)(1).) Risk analysis is one of four required implementation specifications that provide instructions to implement the Security Management Process standard.

Section 164.308(a)(1)(ii)(A) states:
- **RISK ANALYSIS (Required).**
- Conduct an accurate and thorough assessment of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of electronic protected health information held by the [organization].
Audit Concerns – Security Risk Analysis

- The Security Rule doesn’t specify how a risk analysis should be performed.
- There is no “official form.”
- There are far too many differences between covered entities to have one form.

Audit Concerns – Security Risk Analysis

- In WRITING!
- Plan for corrective action with due date
- Documentation of corrective action completion
- Annual update

<table>
<thead>
<tr>
<th>Audit Concerns – Security Risk Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organizational and Management Practices Risk Found?</td>
</tr>
<tr>
<td>Implement confidentiality or non-disclosure agreements with contractors and external entities to ensure the practice’s needs for protection of classified information is met.</td>
</tr>
<tr>
<td>A review process at planned intervals is implemented to ensure the continuing suitability and effectiveness of the practice’s approach to managing information security.</td>
</tr>
<tr>
<td>A formal document that provides an overview of the security requirements for practice information systems and describes the security controls in place (or planned) for meeting those requirements is maintained.</td>
</tr>
<tr>
<td>Changes made to information systems are controlled and documented. The changes are reviewed and approved in accordance with written policy and procedures, including a process for emergency changes.</td>
</tr>
<tr>
<td>Procedures to classify systems and information that is stored, processed, shared, or transmitted with respect to the type of data (e.g., confidential or sensitive) and its value to critical business functions are in place.</td>
</tr>
<tr>
<td>A regular occurring (e.g., bi-annual, quarterly, monthly) process using specialized scanning tools and techniques that evaluates the configuration, patches, and services for known vulnerabilities is employed.</td>
</tr>
</tbody>
</table>
### Audit Concerns – Security Risk Analysis

- **Risk Management Guide:**
- **Guidance on Risk Analysis Requirements:**
- **Sample:**

### 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."

### Office Visits

**Medicare Utilization Patterns Ophthalmology (18)**

<table>
<thead>
<tr>
<th>CPT</th>
<th>New Patients</th>
<th></th>
<th>CPT</th>
<th>Established Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>99205</td>
<td>Level 5 E/M</td>
<td>3%</td>
<td>99215</td>
<td>Level 5 E/M</td>
</tr>
<tr>
<td>99204</td>
<td>Level 4 E/M</td>
<td>29%</td>
<td>99214</td>
<td>Level 4 E/M</td>
</tr>
<tr>
<td>99203</td>
<td>Level 3 E/M</td>
<td>43%</td>
<td>99213</td>
<td>Level 3 E/M</td>
</tr>
<tr>
<td>92204</td>
<td>Comprehensive Eye</td>
<td>61%*</td>
<td>92012</td>
<td>Intermediate Eye</td>
</tr>
<tr>
<td>99202</td>
<td>Level 2 E/M</td>
<td>4%</td>
<td>99212</td>
<td>Level 2 E/M</td>
</tr>
<tr>
<td>99201</td>
<td>Level 1 E/M</td>
<td>&lt;1%</td>
<td>99211</td>
<td>Level 1 E/M</td>
</tr>
</tbody>
</table>

*Combined utilization of E/M and eye codes

Source: CMS data 2012, 18 - Ophthalmology
"It codes for us!"

- Multi-specialty Eye Care practice
  - 6 MDs (Cornea, Glaucoma, Plastics, Comp)
  - 5 ODs
- Implemented EMR – December 2011
- EMR company told practice to let the EMR choose the codes
- EMR chose only E/M codes
  - Ignored Eye Codes

"It codes for us!"

- Significant increase in E/M 99215
  - 2011 - 99215 used 138 times
  - 2012 – 99215 used 5,889 times
  - 42X increase in 1 year

Office Visit – Established

**Blepharitis**

**CC:** Red Eyes (last exam 12 mo)

**HPI:** Patient c/o of very itch of burny-eyes x 3 days. AT help but not much. D/C CL wear. ed eye, OD x 2 days

**Dx:** Blepharitis OU

**Tx:** Lid scrubs and AT, NO CL for 2 weeks. R/T 2 weeks

WHAT CODE DID THE EMR CHOOSE?
“It codes for us!”

What did the EMR choose for the blepharitis patient?

A. 99211
B. 99212
C. 99213
D. 99214
E. 99215
“It codes for us!”

- Moral of the story:
  - Most EMRs do not identify medical necessity
  - Do you need comprehensive history for itchy eyes?
  - Do you need comprehensive exam for itchy eyes?
  - Medical decision making must be considered
  - What would you have chosen in the world of paper?
  - If it sounds too good to be true – it probably is
  - You are ultimately responsible

Exam coding problems with EHR

- Think about this: when you document(ed) on paper, did you feel that you had to fill every space and complete every element?

Exam coding problems with EHR

- Of course not!
- Electronic documentation is no different.
Exam coding problems with EHR

- Every electronic exam does not require every single element found in your comprehensive exam
  - remove sections/tabs that aren't needed for a followup encounter
  - But don't remove MU elements

Exam coding problems with EHR

- Tweak EHR layouts during implementation to minimize tabs, fields, screens
- Don't remove MU elements
- Many MU measures don't need to be documented in every exam:
  - "unique patient"
  - Update as the physician deems necessary (vitals, smoking status,
  - Medication, Allergy, & Problem list

Summary

- Understand the MU criteria (many overlap)
- Prepare for the possibility of a MU Audit
- Use the EMR to enhance your practice (CDS rules)
- Comply with HIPAA / complete the Security Risk Analysis
- Don't forget medical necessity - The practice is ultimately responsible for documentation, coding, and compliance.
- The MU incentive is nice, but not worth the coding and compliance problems that might result if EHR is improperly implemented and utilized.
THANK YOU!

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