EHR: The Good, Bad, and Ugly

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Financial Disclosure

• Jonathan W. Lohr is a consultant with Unibase, LLC and acknowledges a financial interest in the subject matter of this presentation.
• Kevin J. Corcoran is a consultant with Corcoran Consulting Group and founder of Corcoran Compliance Connection and acknowledges a financial interest in the subject matter of this presentation.

Phases of EHR Transition

• Selection
  • Needs analysis
  • Finding a satisfactory system
  • Negotiate a favorable agreement with the vendor
• Implementation
  • Plan
  • Partner
  • Measure results

Selection: The environment

Selection: The Market

• How many vendors?
• Cloud vs. Server
• Interfaced vs. Integrated
• Priority of systems

People
Process
Technology

Clinic Mastery
Health System Mastery

Module Mastery

Module Mastery
Selection: How Many Vendors?
• How many EHR vendors are in the healthcare market?
• How many EHR vendors are in the ophthalmology market?
• What does it mean if you choose a system that is not ophthalmology specific?

Cloud vs. Server?
• Cloud
  • Good
    • Easier configuration
    • Easier update process
    • Quicker to deploy
    • Less up front cost
  • Bad and Ugly
    • Your data is on someone else’s server
    • Can be expensive over time
    • Greatly depends on network speed

• Server
  • Good
    • Control over your data
    • Can be less expensive over time
    • Less dependent on network speed
  • Bad and Ugly
    • Up front costs
    • Requires local support
    • Slower to deploy

Interface vs. Integrate
• Interface
  • Good
    • Faster
    • Minimally disrupts existing operations
  • Bad and Ugly
    • Bridge requires some maintenance

• Integrate
  • Good
    • One point of service
    • Cleaner data transfer
  • Bad and Ugly
    • Eliminates some options (i.e., disparate systems that may serve practice better)

Priority of Systems
• Is the tail wagging the dog?
• Should the priority be the same for everyone?
Selection: Know Your Practice

- Budget
- Goals
- Plan
- Expectations

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost</th>
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<tbody>
<tr>
<td>Hardware</td>
<td>$30k</td>
</tr>
<tr>
<td>Software</td>
<td>$100k</td>
</tr>
<tr>
<td>Training</td>
<td>$25k</td>
</tr>
<tr>
<td>Maintenance</td>
<td>$10k</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$165k</strong></td>
</tr>
<tr>
<td>Productivity Loss</td>
<td>$150k</td>
</tr>
<tr>
<td><strong>Total Cost</strong></td>
<td><strong>$315k</strong></td>
</tr>
<tr>
<td>+Benefit</td>
<td>$200k</td>
</tr>
<tr>
<td><strong>Net Gain:</strong></td>
<td>-$115k</td>
</tr>
<tr>
<td><strong>10 Year Net Gain:</strong></td>
<td>???</td>
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Selection: Know Your Practice

- Plan
- Demos
- Site Visits
- Contract Neg.
- Sign Contract
- Go Live

<table>
<thead>
<tr>
<th>Item</th>
<th>Month</th>
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</thead>
<tbody>
<tr>
<td>Plan</td>
<td>January</td>
</tr>
<tr>
<td>Demos</td>
<td>March</td>
</tr>
<tr>
<td>Site Visits</td>
<td>May</td>
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<tr>
<td>Contract Neg.</td>
<td>July</td>
</tr>
<tr>
<td>Sign Contract</td>
<td>August</td>
</tr>
<tr>
<td>Go Live</td>
<td>December</td>
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</tbody>
</table>

Implementation

- Planning documents
- Communication plan
- Training plan
- Project plan
- Convert from paper
- Convert from failed EHR

Implementation: Planning

- As Is and To Be Analysis
- Identify bottlenecks

Implementation: Design

- Unit test
- Integration test
- Workflow test
- Build training materials
Implementation: Train and Deploy

• Determine proper mix of training
• Ready production environment
• Go-live

Change Management

• Communication
• Issue management

Final Thoughts

• Good
  • It’s no longer: “Are we the best?” Now, it’s: “Are we getting better faster than everyone else?”
  • A little change is progress, a lot of change is paralysis
• Bad and Ugly
  • The prize for winning the pie eating contest...More pie
  • The longer you wait, the tougher it is to catch up

Appendix

• www.healthit.gov/providers-professionals/ehr-implementation-steps/step-1-assess-your-practice-readiness
• www.ascrs.org/sites/default/files/resources/ASCRSASOAGuidetoEHR_2013%20Spring.pdf
  • Page 11 and 12 provide a checklist

EHR: The Good, Bad and Ugly

• Compliance
• Auditing
• Billing
• Reimbursement
• Meaningful Use
**HIT Bonus in Stimulus Package**

- 2009 - American Recovery and Reinvestment Act (ARRA) authorized CMS to provide financial incentives for physicians who are “meaningful users” of certified electronic health record (EHR) technology (and penalties for those who do not by 2015)

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**Meaningful Use**

- It’s not about the bonus money…

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**Meaningful Use**

- It’s complex
- Three (3) stages
- Vendor support needed

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**Audits of HIT Bonus Claimants**

- Congress mandated auditing process in the law (ARRA) that authorized EHR
  - Proof that the system used is certified
  - Documentation that core objectives were met
  - Documentation that menu objectives were met
  - Show Clinical Quality Measures were met
- Figliozzi and Company – Accounting firm in Garden City, NJ
- A doctor or hospital found ineligible for an EHR incentive after an audit must return the bonus

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**Compliance**

- Does EHR make you vulnerable?
- Does EHR encourage problem behavior?

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**Problems from Copy-Paste**

- Integrity of record questioned – misrepresentation
- Confusion from nonsensical language
- Note bloat
- Difficultly 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
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”

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

History of Present Illness

Chart Documentation

| CC | Can be obtained by physician or staff |
| HPI | Must be obtained by physician for E/M coding |

Performed by JCR, MD  Scribed by S. Brown, COA

Auditing

- Is it easy to find the elements of the chart?
- Is the chart complete?
- Are tests easy to interpret? Timely?
- Does the system support proper charting?

Health Information Management

- How long can a medical record remain open (incomplete) and unsigned?
- What reason(s) justifies keeping a record open?
- How is a closed record changed?
- What are your HIM policies?
- Does management track changes?

Paper Records

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

**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

**Billing**

- E/M
- Eye codes
- HCPCS
- ICD-9
- ICD-10
- PQRS
- eRx

**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**

<table>
<thead>
<tr>
<th>CPT</th>
<th>New Patients</th>
<th>λ</th>
<th>CPT</th>
<th>Established Patients</th>
<th>λ</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>
<td>1%</td>
</tr>
<tr>
<td>99204</td>
<td>Level 4 E/M</td>
<td>29%</td>
<td>99214 92014</td>
<td>Level 4 E/M Comprehensive Eye</td>
<td>52%*</td>
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<tr>
<td>99203</td>
<td>Level 3 E/M</td>
<td>61%*</td>
<td>99213 92012</td>
<td>Level 3 E/M Intermediate Eye</td>
<td>43%*</td>
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<tr>
<td>92004</td>
<td>Level 2 E/M</td>
<td>6%</td>
<td>99212</td>
<td>Level 2 E/M</td>
<td>4%</td>
</tr>
<tr>
<td>92002</td>
<td>Intermediate Eye</td>
<td>1%</td>
<td>99211</td>
<td>Level 1 E/M</td>
<td>&lt;1%</td>
</tr>
</tbody>
</table>

*Combined utilization of E/M and eye codes
Source: CMS data 2012, 18 - Ophthalmology
**Office Visits**

*Medicare Utilization Patterns Optometry (41)*

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<tr>
<td>99205</td>
<td>Level 5 E/M</td>
<td>&lt;1%</td>
<td>99215</td>
<td>Level 5 E/M</td>
<td>&lt;1%</td>
</tr>
</tbody>
</table>
| 99204 | Level 4 E/M  | 12%| 99214 | Level 4 E/M Comprehensive Eye | 56%*
| 99203 | Level 3 E/M  | 78%*| 99213 | Level 3 E/M Intermediate Eye | 36%*
| 99202 | Level 2 E/M  | 10%*| 99212 | Level 2 E/M           | 7% |
| 99201 | Level 1 E/M  | <1%| 99211 | Level 1 E/M           | <1%|

*Combined utilization of E/M and eye codes

Source: CMS data 2012, 41 - Optometry

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**Challenges in the Optical Dispensary**

- Error prone
  - Coding errors
  - Modifier errors
  - Date errors
- Required paperwork
  - Detailed Rx
  - ABN
  - Proof of delivery

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**Other Considerations of EHR**

- Compliance
- Auditing
- Billing
- Reimbursement
- Meaningful Use

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**What's Valuable in EHR?**

- Comprehensive structure and function
- Ease of understanding
- Ease of use
- Speed
- Affordable
More help...

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

info@unibasehealthcare.com
or
www.unibasehealthcare.com

More help...

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

(800) 399-6565
or
www.CorcoranCCG.com
www.CorcoranC3.com