EMR Challenges for Retina
Paper is Gone

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EMR Documentation Issues
“Garbage in….Garbage out”

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

Paper vs. EMR
Paper vs. EMR

- Paper
  - Not always enough documentation
- EMR
  - 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 Challenges

- Too much documentation
- Contradictory or erroneous entries
- Prompting billing for higher level exams
- 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
- 99204 New Patient Level 4 E/M Code
  - Comprehensive history
  - Comprehensive examination
  - Medical decision making of moderate complexity

Source: CPT Manual

E/M Coding

- 99205 New Patient Level 5 E/M Code
  - Comprehensive history
  - Comprehensive examination
  - Medical decision making of high complexity

Source: CPT Manual

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 documentation before data is locked

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 N5
  - 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
Case Study

- 2 Aflibercept 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
EMR Hiccups

- 65 year old male presented for evaluation of existing condition, GLAUCOMA in both eyes for several years. The timing is described as all the time. Quality is fixed. Relief is experienced from using drops as directed. Patient described the following signs and symptoms: none currently to report.

- 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.

EMR Hiccups

- 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
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

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

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

- Retinal detachment
- Laterality
  - Single break
  - Multiple breaks
  - Giant tear
  - Retinal dialysis
  - Total

Code Structure Variability

- Diabetes Mellitus
  - No laterality
  - Severity
  - Combination codes
    - Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema
    - ICD - 10 = E11.321

Code Structure Variability

- Diabetes Mellitus
  - No laterality
  - Combination codes
    - Type 2 diabetes mellitus with proliferative diabetic retinopathy with macular edema
    - ICD - 10 = E11.351
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
Compliance

Who’s Watching

- Office of Inspector General (OIG)
- Comprehensive Error Rate Testing (CERT)
- 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

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

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### 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

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### 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
- Determine what areas of EMR can be accessed by whom
- 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

Summary

- 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
- Review compliance policies related to EMR
- EMR is here to stay

More help...

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