Unintended Consequences of Electronic Health Records

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The instructor acknowledges a financial interest in the subject matter of this presentation.

EHR Documentation Issues
“Garbage in . . . Garbage out”

Problematic Chief Complaints
Examples
• “Decreased vision in both ears”
• “Patient complains, no complaints”
• “Diabetes in both eyes 4 years”
• “Borderline diabetes, it affects vision, not affected”
• “IOL eval in both eyes for one year”

History of Present Illness (HPI)
Challenges
• Expands on the CC
• Develops the CC
• Some EMR create a “narrative” or “paragraph”
• Read the final product it must make sense

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

- 53 year old female complains of growth in left eye for 1 year. The timing is described as constant.
- 66 year old female presented for evaluation of existing condition, ARMD. Timing is described as all the time. Severity is described as unknown.

HPI EMR “hic-ups”

- 64 year old male presents for evaluation of existing condition, GLAUCOMA in both eyes for several years. The timing is described as constant. Severity is described as unknown. Relief is experienced from timolol BID, latanaprost in the evenings. Pt is here for IOP check and VF.
- 66 year old male presented for evaluation of existing condition, lattice degeneration in both eyes for a few years. The timing is described as constant. Severity is described as faint.

Problematic Exam Documentation Examples

- CVF – fixes and follows OU – patient is monocular
- Lens – “clear OD” – patient is scheduled for cataract surgery OD
- External / lids – “WNL OS” – Procedure note for epilation of lashes LLL
- SLE – blank – impression indicates corneal ulcer OD
- VA = 20/20 OS – Patient had enucleation OS 3 mos. Prior
- Retinal periphery – “360 degrees, no holes, detachments, breaks” (Patient not dilated.)

EMR Consequences

- What do these examples say about our records?
- Quality of the work?
- Integrity of the record?
- Is it believable?
- Can you defend it?

Problems from Copy-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

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

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**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.”

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### Office Visits

**Medicare Utilization Patterns Ophthalmology (18)**

<table>
<thead>
<tr>
<th>CPT</th>
<th>New Patients</th>
<th>Established Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>99205</td>
<td>Level 5 E/M</td>
<td>3% Level 5 E/M 1%</td>
</tr>
<tr>
<td>99204</td>
<td>Level 4 E/M</td>
<td>29% Level 4 E/M 51%*</td>
</tr>
<tr>
<td>99203</td>
<td>Level 3 E/M Comprehensive Eye</td>
<td>61%* Level 3 E/M Intermediate Eye 43%*</td>
</tr>
<tr>
<td>92002</td>
<td>Level 2 E/M Intermediate Eye</td>
<td>6%* Level 2 E/M 4%</td>
</tr>
<tr>
<td>99201</td>
<td>Level 1 E/M</td>
<td>&lt;1% Level 1 E/M &lt;1%</td>
</tr>
</tbody>
</table>

*Combined utilization of E/M and eye codes

Source: CMS data 2011, 18 - Ophthalmology

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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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**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)
HIPAA Breach

- PHI for ~ 192 patients left on subway train
- Documents were never recovered
- Penalty – $1 million HIPAA settlement with DHHS OCR
- Burdensome Corrective Action Plan required

Source: Security, Privacy and The Law 3/13/11

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

Corrections - Paper Records

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

What do you do in an EMR?

Addendums

- Addendum – new documentation used to add information to an original entry (e.g., late, missing 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

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

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

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

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

“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

Source: Medical Economics, June 6, 2003
“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 12mo)

HPI: Patient c/o of very itch, 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. RTC 2 weeks

What code did the EMR choose?

“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 to good to be true – it probably is
  - You are ultimately responsible

Closing Thoughts

- Institute training and set expectations to limit problems.
- Take responsibility for what you put in the record as a tech or scribe.
- Read it, does it make sense?
- Would you have written “that” in a paper chart?
- Verify copy/paste, carry forward data for accuracy
- Not every blank must be completed, consider medical necessity
- The practice/physician is ultimately responsible for the content and accuracy of the record
- Periodically review your charts for quality and accuracy.

Questions
More help…

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

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