Presentation should be given by a knowledgeable chapter member who is comfortable with the subject content

Evolving Electronic Medical Record

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AAPC
CHAPTER ASSOCIATION

Agenda

Electronic Medical Record

- Evolution of medical records
- Advantages of Electronic Medical Records
- Challenges & Risks
- Cloned Notes & Templates
- Attorney General's View of the EHR
- CMS E/M Initiative
- Communications

A Trip Down Memory Lane…

Remember the paper ?

- Where are those paper records?
- Notes written in margins, below notes of residents & medical students, on lost pages
- Edits with crossed out words
- Sometimes illegible
- Authorship shown by ink, handwritten
- Sometimes…no note
- Shadow Charts in the Departments

The Advantages are Enormous!

This was not just an event but rather the starting point of a process to develop a comprehensive medical record over years.

- Design was big, complex, & took a long time.
- Required rethinking clinical workflows and documentation to fit the time and the advantages of an electronic medical record

The Advantages are Enormous!

- All notes in one place
- More complete record of patient's condition & care.
- Templates available to save time in documenting
- Legible notes to read
- Improved Decision support
- Better communication with others providing care to the same patient.
- Improved patient safety
- Remote access to make decisions

Challenges in the EHR

What is what & where is it in the EHR?

- Closing sessions before someone else documents
- Determining whether documentation originates in EHR
- Locating the orders from MD's
- Who documented what piece of the service
- Identifying signatures & authentication
- Finding scanned documents in the system
- Incorrect or incomplete system phrases or templates
- Flawed workflows associated with documentation

Compliance Risks

- Documentation of services not provided
- Using medical student's note as own note to bill
- Using scribes to document services
- Populating the note with conflicting or inaccurate information
- Password sharing
- Using copy/paste function without editing the note

These things may happen intentionally or inadvertently

Fraud Awareness

- Whether it was intentional or done inadvertently, the documentation may be incorrect for that date of service.
- By signing the documentation, the provider attests to the fact that the services were performed as documented in the note.
- If a portion of the services are documented but not performed, the provider has falsified the record and it could be viewed by the Federal Government as fraudulent.
- The law does not require proof of intent to defraud; recklessness can be enough to prosecute.

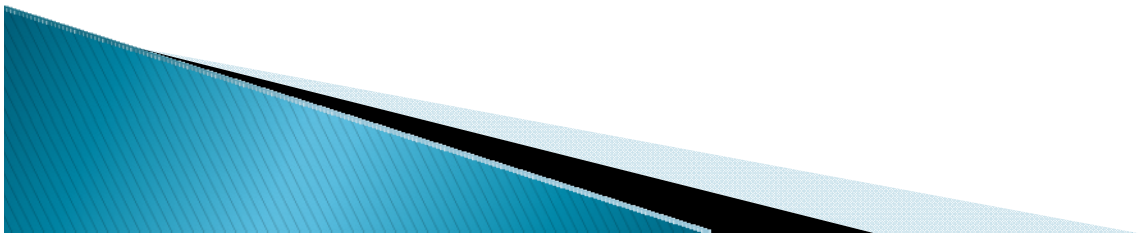
It's not just Medicare Looking

- Health & Human Services (HHS) and the Attorney General wrote a strongly worded letter to the top 5 major health care Organizations about the electronic health record (EHR)

- "EHRs may be contributing to higher Medicare costs because they make it easier to bill more for services." Major criticism was ***upcoding.***

Finding the Documentation

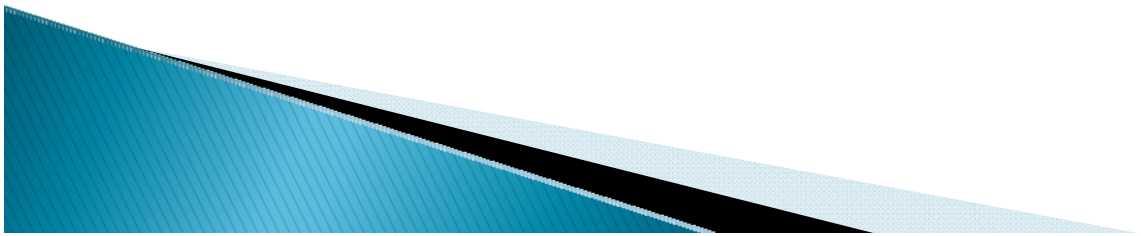
- *<u>It use to be</u>*: ***If it isn't documented, it didn't happen.***
- *<u>Now it is</u>*: ***If it's documented, did it happen?***
- Moved from no note to note bloat



Ease of Duplicating Documentation

There are several ways to copy documentation. Here are a few

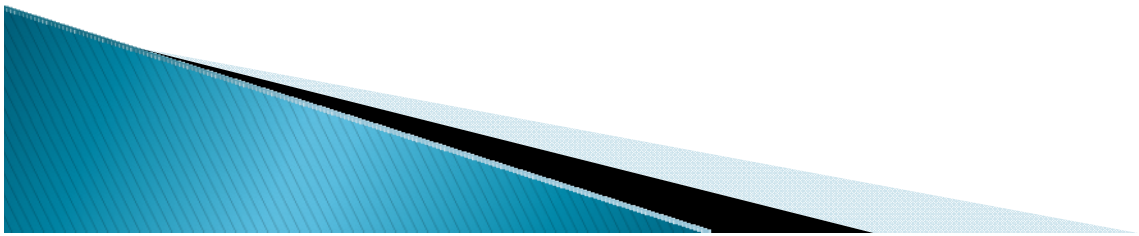
- Copy & paste function
- Copy forward function
- Dot phrases
- Smart sets



Cloned Notes

What is a cloned note?

A cloned note is one that is copied in part or in whole from another note.



Symptoms of a Cloned Note

Established patient/subsequent inpatient visit:

- PFSH
- Allergies
- Medication List
- Full ROS
- Same exam for every patient, every visit
- Same amount of time for each visit
- Old labs or radiology
- Issues listed in the A&P not otherwise noted
- Conflicting information often in ROS & HPI

Treating the Disease

- Meet with provider to fact find about what was done
- Be prepared. Take a few examples to review.
- Ask specifically about the issue but in a way to gather the facts & not assume you know.
- Get all the facts before you educate.
- Educate them about why accurate documentation is essential.

Treating the disease

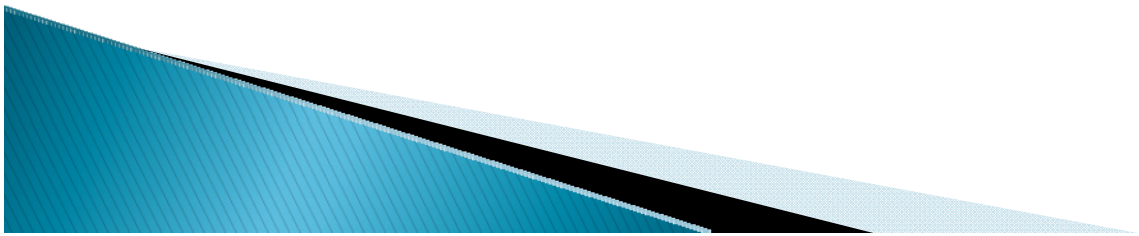
- If you see something "bad" in a note, don't assume – ask questions first:
  - How do you pick a LOS?
  - It looks like much of your HPI is the same as last visit. Are you bringing forward old information so you have a running log of the patient's history?
  - It looks like you document PFSH at each visit. Do you review or discuss the patient's history at each visit?
  - It looks like the patient came in for an ear infection. I see that you mentioned her diabetes in your Plan. Was this addressed at that visit?
  - How do you count your time for your clinic visits?

When is it OK to Copy a Note?

- If copying a note from a previous visit, make sure it is edited thoroughly to represent today's visit.
- If a history is carried forward with each note, identify it by a statement such as "History obtained from a previous visit" and/or identify the history obtained today as "Interval History."
- If the same exam is repeated from a previous visit and there is no change, indicate the exam was the same as the previous date with no change, giving the previous date as reference.

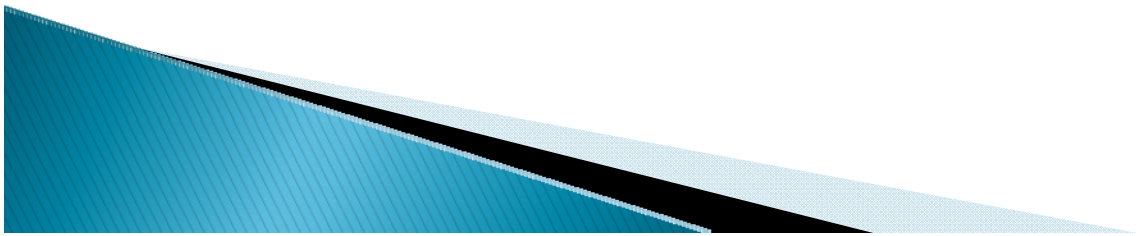
Templates

- Many templates are used for different types of services to save time in documentation.
- Providers can add new templates, edit them, or delete them and they can share them with others.
- Macros are used to streamline specific information in templates to save time in documentation
- If there is a problem with a template, it may be a wide spread problem when sharing.



Emailing Providers

- Be clear and concise.
- Spell check and proof-read your email prior to sending it.
- Let them know what the missing item is from the note.
- Ask them if it was performed.
- Ask them if they would like to addend.

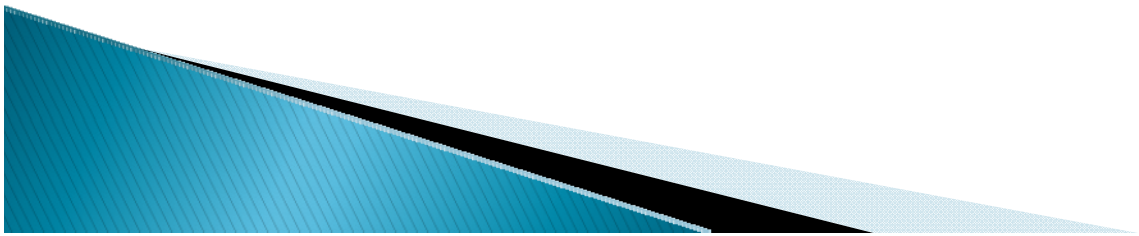


Provider Email Etiquette

- "You need to addend your note to say you were present". *Better: "If you were present, would you like to addend to state that?"*
- "You need to do 10 ROS to bill a 99204." *Better: "A 99204 requires 10 ROS. Did you do 10 or more? If so, would you like to addend to add the additional information?"*
- "Your time statement doesn't say 'over 50% in counseling'. You need to addend." *Better: "Did you spend at least half the visit in counseling? If so, would you like to addend to include that information?*

Communication Etiquette

- Always think twice before writing an email.
- Emails are forever. You can assume it is backed up somewhere.
- Write as if the email would be presented in a court room or shared with the most hostile person you know.
- Never communicate bad news by email or voice mail, only in person or live by phone.



Communication

- Clean up your “sent” emails frequently. If you don’t need them, DELETE THEM.
- When the Government comes knocking, they will search emails for key words like: jail, fraud, OIG, prison, orange (jump suit), incorrect, un-billable.
- Emails are a dream come true for law enforcement.

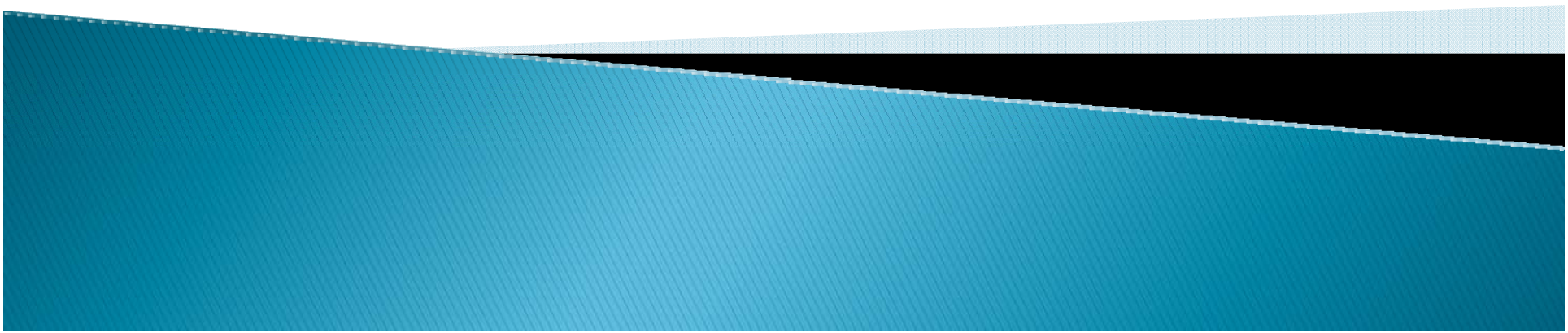
CMS Initiative

- Exploring a redesign of requirements for E/M services to fit the electronic medical record
- Reviewing the teaching physician rules
- Reviewing the payment model for clinic services

Pop Quiz!

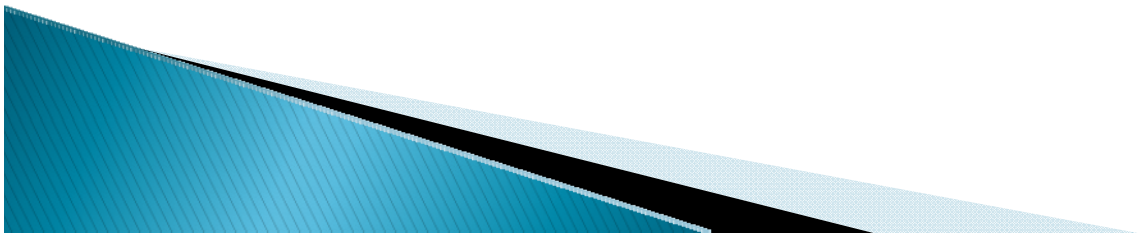
- Get into groups of 3-5 people
- Select a Secretary and a Speaker
- You have 15 min to review the note:
  - Identify compliance concerns
  - What questions would you ask this provider?

Time's Up!!



Your First Impressions of this note?

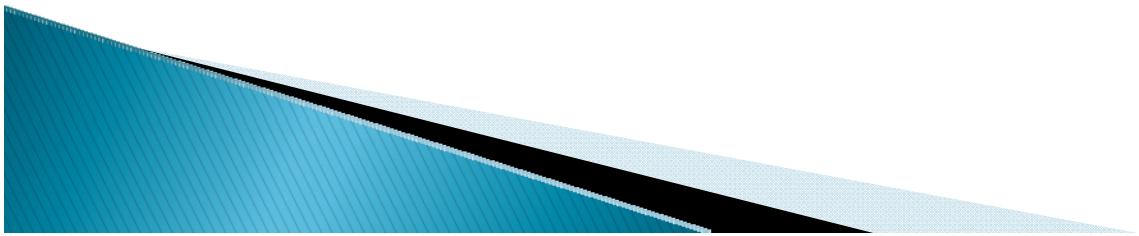
- Do you think this note is an accurate reflection of what occurred at that visit?
- Is it easy to tell what happened in this visit?
- Does this note exhibit signs of a cloned note?
- What signs did you see?



How would you educate this provider?

- What questions would you ask?
- What suggestions would you make for improving his/her template?

Questions?



The information contained in this presentation is current as of 6/1/2013.

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