The Slippery Slope of Electronic Health Record Systems

Presented by:
Maryann C. Palmeter, CPC, CENTC

Learning Objectives

• Identify key benefits of an electronic health record system (EHR)
• Define “note cloning,” the Federal government’s view on it, and how it can negatively impact patient care and health studies
• Learn risks associated with copy forward, copy and paste, and auto-neg functionalities
• Identify results of invisible authorship and how this could lead to allegations of fraud
• Understand the importance of updating information in the electronic health record
Key EHR Benefits

- Legible documentation
- Reduced transcriptions costs
- Less chart filing, chart pulls, & chart space
- Improved continuity of care & info access
- Clearer prescriptions, more efficient drug interaction checks, formulary checks
- More efficient disaster recovery
- Environmentally friendly

Key EHR Dangers

- Note Cloning
- Copy Forward Functionality
- Documentation by Exception
- Overdocumentation
- Invisible Authorship
- False or Outdated Data
- Negative Patient Impact
The Clone Wars

Obi-Wan: “Your clones are very impressive. You must be very proud.”

Yoda: “Once you start down the dark path, forever will it dominate your destiny, consume you it will.”

Government Focus on Cloning

- Local MACs define Cloning and Repercussions
- 2011 and 2012 OIG Work Plans
- Underlying Medicare Regulations
Cloning Definition

Per FCSO:
Documentation is considered cloned when each entry in the medical record for a patient is worded exactly alike or similar to the previous entries. Cloning also occurs when medical documentation is exactly the same from patient to patient.

Lesson for the Day....
Lucy, you got some splainin’ to do!

Documentation by Exception

- Documentation by exception functions should be avoided
- Sometimes referred to as “auto-neg”
- Dangerous to the organization and the individual practitioner
- Foster the ability to commit fraud, intentionally or unintentionally
- May compromise good patient care
ROS Example with Auto-Neg

ROS
General: Denies fevers, chills, sweats, anorexia, c/o fatigue.
Eyes: denies blurring, irritation, discharge, vision loss.
ENT: denies ear pain or discharge, tinnitus, decreased hearing.
CV: denies chest pains, palpitations
Resp: denies cough, dyspnea, excessive sputum
GI: recent rectal bleeding
GU: no dysuria, hematuria, discharge, or incontinence
MSK: c/o severe back pain, joint pain, joint swelling, muscle cramps
Skin: denies rash, itching, dryness, suspicious lesions
Neuro: denies transient paralysis, weakness, paresthesias, seizures
Endo: denies cold intolerance, heat intolerance, polydipsia, polyphagia, polyuria
Heme: denies abnormal bruising, bleeding, enlarged lymph nodes
Immune: denies urticaria, hay fever, persistent infections, HIV exposure
Psych: anxiety and depression

Exam with Auto-Neg

<table>
<thead>
<tr>
<th>Physical Exam</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eyes</strong></td>
</tr>
<tr>
<td><strong>Ears</strong></td>
</tr>
<tr>
<td><strong>Nose</strong></td>
</tr>
<tr>
<td><strong>Throat</strong></td>
</tr>
<tr>
<td><strong>Neck</strong></td>
</tr>
<tr>
<td><strong>Respiratory</strong></td>
</tr>
<tr>
<td><strong>Cardiovascular</strong></td>
</tr>
<tr>
<td><strong>Abdomen</strong></td>
</tr>
<tr>
<td><strong>Lymph nodes</strong></td>
</tr>
<tr>
<td><strong>GU</strong></td>
</tr>
<tr>
<td><strong>Extremities</strong></td>
</tr>
<tr>
<td><strong>Musculoskeletal</strong></td>
</tr>
<tr>
<td><strong>Skin</strong></td>
</tr>
<tr>
<td><strong>Neurologic</strong></td>
</tr>
<tr>
<td><strong>Psychiatric</strong></td>
</tr>
</tbody>
</table>
• Does the system allow for "soft" copy forward? Or does it require re-validation of the copied information?

• What audit trails are available? Are audit trails printable?

• Is information carried forward easily identifiable (e.g., different color, highlighted text)? How are source documents identified (date, time, author)?

• Can blocks of content be individually authenticated allowing for original and copied info in same note?

• How is re-authenticated info identified?
Example 1

Physical Exam
Abd: soft, nondistended, with normoactive bowel sounds. No hepatosplenomegaly, no masses, nontender to deep palpation

Assessment
A mass was palpated in the abdomen (789.30)

Example 2

Assessment
Diabetes mellitus (250.00)

Plan
Example 3

Plan

? Pancreatic mass – ultrasound and MRI reviewed. GI consult reviewed.

Example 4

Chief Complaint: sinus problems

HPI: Patient presents with 1 wk “stuffy feeling” in nose, yellow mucus, cough, headache, itchy, watery eyes
Example 4 (cont.)

ROS
Eyes: denies blurring, irritation, discharge, vision loss
ENT: denies ear pain or discharge, tinnitus, decreased hearing See HPI
Resp: denies cough, SOB, dyspnea, excessive sputum
GI: denies rectal bleeding ???

Example 5

Vital Signs recorded by MA at 11:03 am
Pain Scale: 10

Physician’s HPI at 11:23 am
Pain is shooting constant, 7/10.
Invisible Authorship

Dangers of Invisible Authorship

- Lends confusion or false appearance of true service provider
- True author not visible in printed record or through normal view mode
- If printed audit trail possible, would have to send to payer if records requested
- May result in overpayment if true provider NPP or ancillary staff
Recommendations

- Identification of author of each piece of note must be readily apparent.
- Do not limit note author identification to a function with restricted access.
- Block ability to copy after finalization.
- Allow tracking of the history of each person who has entered or reviewed information.
- Develop system to identify original source document.
Garbage Notes

You’re still here? Hey, why don’t you go read a book or something?

Hospital? You want to take me to the hospital? With all those clean white sheets, and those nice clean nurses and doctors?

• Lengthy dx test results
• Misleading problem lists
• Outdated medication lists

Lengthy Dx Test Results

• Can lead to 20 page notes
• Makes it difficult for others to sift through for relevant information
• Old results need current notation
• Author of report may be misconstrued
• May lead to upcoding
### Misleading Problem Lists

- Needs to be updated
- Needs to be relevant
- Can become contradictory if not managed
- Should not be used for billing
- Pick lists not sub for ICD-9

### Outdated Medication Lists

- Medication reconciliation is key
- Plan of treatment/orders should jibe with medication list
Example 6

3/26 Plan: Physician states, “I told patient I would be happy to continue to treat him w/non narcotic pain meds in the future but that if he needed narcotics, he would need to see another physician. He said he would find another physician.”

Orders: Renew Oxycodone-Acetaminophen 10-325 MG Oral Tablet...

No Rx renewal on this DOS

Patient Impact
Recap

- Use caution
- Update frequently
- Incorporate audit trails
- Develop policies
- Monitor compliance with policies

Questions?