EHR Chart Auditing Techniques

Bridging the chasm between electronic health records & compliance, quality care, $$$

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Disclaimer

• This presentation is designed to provide accurate and authoritative information in regard to the subject matter covered. The information includes both reporting and interpretation of materials in various publications, as well as interpretation of policies of various organizations. This information is subject to individual interpretation and to changes over time

• Presenter has personal interests in consulting, presenting, writing about, and developing software in order to help physicians achieve compliant medical records and to help them facilitate quality patient care
Attendee Demographics

• E/M Coding?  E/M auditing?
• Outpatient?  Inpatient?
• Context?
  – Medical practice
  – Hospital / academic center
  – Medicare or insurer
  – Consultant

Attendee Demographics

• Format of records audited
  – Writing
  – Dictation (with or without macros?)
  – Hybrid writing + dictation
  – EMR / EHR
• Auditing standard (& tools) used?
  – CPT compliant
  – Marshfield tool
  – Trailblazer tool
  – Other
• Familiar with Practical E/M &/or Practical EHR?
Two Sides of the Same Coin?

- What is the difference between coding & auditing?
- What features may be extra with auditing?

Auditor’s Responsibilities

- We must maintain accurate, meaningful, and reliable auditing and education in order to achieve accurate, meaningful, and reliable documentation and coding
- Which team is presenter’s favorite team at the super bowl?
Concentrate on Challenges in the “Grey Zone”

- We can agree to disagree,
- But to do so reasonably, we must understand the areas of uncertainty and the reasons for each interpretation
- We want our own approach to succeed if audited

“A problem stated is well on its way to solution”
  – (John Dewey, philosopher, 1930)

The Challenging Case of Dr. X

- 38 year old pediatrician
- Med school and residency = zero training in coding and compliance
- Practice: coding by office staff (guided by sr. MD) all at level 4 & 5
- 4 years in, realized code levels too high and \downarrow
- Doesn’t know CPT or E/M

Audit by Medicaid:
  - 20 charts (multiple visits) of charts from 4-7 yrs ago
  - Extrapolated for 7 years
  - Request for repayment = $300,000

What would you do with this case?
The Auditor’s Path for Dr. X

• Audit the doc:
  – Perform an audit of the 20 charts
  – Do the E/M statistics for 7 years

• Audit the carrier:
  – Find out who and what tools used
  – Obtain the actual audits
  – Obtain the extrapolation data

• Audit the carrier’s audits

• Question: would your own audits withstand a compliant audit
  – Why, why not??

EHR Audit is an E/M Audit (already challenging enough) on Steroids

• Most physicians’ medical records are not E/M compliant
  – EHR developers asked those same docs for guidance in developing the electronic H&P

• Most EHR coding engines are non-compliant (no NPP, no qualitative features, etc)
  – Screens built 1:1 on engine

• PLUS, overcome data entry challenges → non-compliant data entry functionality
  – Attack of the CLONES

Note: dictation with macros now often mimicking EHR problems
Auditing EHR Documentation of E/M Involves a Three-Step Process

- Understanding complex & sophisticated E/M principles
- Dealing with the complex challenges of EHR screen designs and functionality
- Creating effective educational approaches to provide solutions to the problems

Questions About E/M Auditing Intro?
Agenda

• Your *Hot Issues*
• Setting the table: ADVANCED basic E/M postulates
• Brain-storming the *Hot Issues*
  – Section-by-section E/M dialogue (history, exam, MDM, NPP, time-based services)
• The issue of non-compliant data entry functionality – *cloned* documentation
• Tool kit for EHR auditing
• ? Solutions for MDs: tools, methodology, training

Agenda

• For each *Hot Issues consider*:
  – Quantitative and qualitative requirements (per CPT and Documentation Guidelines)
  – Impact of medical necessity
  – E/M issues: grey zones, areas of controversy
  – ? Questions regarding short cut audit/coding tools
  – Problems introduced by EHR designs & functionality, including cloned documentation
What are YOUR Hot E/M & EHR Issues?

Setting the Table
E/M Evolution (by AMA & CMS)

→ Practical E/M Guidelines

Non-compliant short cut tools

E/M Evolution

  - Defines 7 elements of CPT
  - Descriptions all in qualitative terms
- Documentation Guidelines 1995
  - *Qualitative* criteria for all 3 key components
  - *Qualitative* criteria for encounters dominated by counsel/coord.
  - Role of NPP in extent of history & exam obtained and documented
  - Introduces Table of Risk
  - *Quantitative* criteria for aspects of medical history
E/M Evolution

• Documentation Guidelines 1997
  – Reiterates all 1995 criteria
  – History: HPI adds \textit{status of \geq 3 chronic or inactive conditions}
  – Examination: adds (\textit{quantitative}) general multi-system exam & 11 single-organ system exams

• April 1998 fly-in meeting
  – Compromise: accepts ‘95 or ‘97 guidelines (issues with this?)

• \textit{Practical E/M} 2005 (approved & published by AMA)
  – \textit{Quantitative} criteria for aspects of medical decision making
  – Methodology for integrating medical necessity into E/M workflow
  – IMR tools to ensure compliance, promote efficiency & quality

• \textit{Practical E/M} 2008
  – Identifies “missing link” between E/M and medical quality

Medical Necessity: Pivotal Concept for Sustainable Audits

• What is medical necessity?
• What is E/M system’s measure of M.N.?
• Do you consider M.N. in your audits?
• How do you incorporate M.N. in your audit evaluations and reports?
  – At end for down-coding?
  – Other?
  – Examples?
Medical Necessity

• “Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code”
  – Medicare Claims Processing Manual, Chapter 12, section 30.6.1

• Definition(s)?
  – Service that the physician determines is required to address a patient’s medical condition? (Why not?)
  – Service that meets the standard of care for addressing a patient’s medical condition?

*Medical Necessity Definition

• Synopsis of the comprehensive definition applied in the HMO class action lawsuit settlements:
  – Health care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are
  – (a) in accord with generally accepted standards of practice*;
  – (b) clinically appropriate, in terms of type, frequency, extent, site and duration
  – (c) considered effective for the patient’s illness, injury or disease;
  – (d) not primarily for the convenience of the patient or Physician
  – (e) not more costly than an alternative service that is at least as likely to produce equivalent therapeutic or diagnostic results
Medical Necessity Definition (2)

• ‘For these purposes, ‘generally accepted standards of medical practice’ means
  – Standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community
  – Physician Specialty Society recommendations
  – The view of Physicians practicing in relevant clinical areas
  – And any other relevant factors”

• Preventive care may be Medically Necessary, but coverage for Medically Necessary preventive care is governed by the terms of the applicable Plan Documents”

Which of the 7 Elements of E/M Directly Relates to Medical Necessity?

• Medical History
  – Chief Complaint; HPI; PFSH; ROS
• Physical Examination
• Medical Decision Making (MDM)
  – Data reviewed &/or ordered
  – # of diagnoses &/or treatment options
  – Risk of problems, tests, treatments
• Nature of the presenting problem (NPP)
• Counseling
• Coordination of Care
• Time
Survey: Impression of Physicians’ Current Medical Records

- Core concept: “over-coding” vs. “under-documenting”
- Related to severity of patient illness (NPP), what % of physicians are:
  - Coding accurately >95% of the time?
  - Over-coding?
  - Under-coding?
- Compared to level of care warranted by NPP, what % of physicians are:
  - Documenting appropriately >95% of the time?
  - Under-documenting?
- Note: without a comprehensive history, MD cannot reasonably assess severity of NPP(s)

Fundamental E/M Postulates

- If care was not documented in the medical record, it was not done (CMS Carriers’ Manual, section 7103.1(I))
- In accordance with the Social Security Law, Medicare will not pay for services that are not medically necessary (Soc. Sec. section 1862)
  - “Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code” (Medicare Claims Processing Manual, Chapter 12, section 30.6.1)
- Automation is NOT documentation (EHRs)
- Examine the educator’s “flip side"
**Fundamental E/M Education Postulates**

- If care was documented in the medical record, it was done.
- Medicare will pay for services that are medically necessary
  - (and were performed & documented)
- *Documentation* of history & exam do NOT involve automation
  - Controlled *semi-automation* effective & safe for some of MDM elements

**General E/M Issues Common in Paper Records (& Often Exacerbated in EHRs)**

- Failure to incorporate *medical necessity* into coding and guidance for levels of care
- Consider only the *quantitative* elements of E/M & documentation guidelines, ignoring the *qualitative*
Documentation Guidelines Postulate

- For compliance & quality, which E/M criteria are dominant?
  - Quantitative
  - Qualitative
  - Bothitative

Where Does CPT’s E/M System Come From?
Linking E/M Compliance With Quality Care/Data Integrity

• E/M is based on the standard reference text used to teach physicians the optimal approach to diagnosis and care

• That is, the E/M system, when used correctly and efficiently, is a codification of the comprehensive H&P taught to student physicians as the ideal for high quality care (and cost effectiveness)

• CPT’s E/M Section & Doc. Guidelines match concept for concept, and often almost word for word, with the “Bates Guide”

• Therefore E/M is not just a coding system, it can be used as a framework to guide and facilitate quality patient care
  – i.e., E/M compliance is a reasonable model of quality care

• Note: This concept SHOULD help us help physicians get on board with compliant documentation & coding!
Quality H&P Presents a Three-Sided Benefit for MDs

- Promotes Quality Care
- Provides Liability Protection
- Fulfills Compliance Needs
- E/M compliance is a key to unlock this inter-relationship

Challenges in the “Grey Zone”

- Documentation missing elements of E/M care
- Dealing with imprecise (qualitative / subjective) criteria
- Addressing “short-cut” tools that are incomplete or incompatible with CPT and Documentation Guidelines
- MDs challenging clinical relevance of E/M
- EHR complexities
  - Non-compliant coding engines
  - Inadequate data entry screen designs
  - Non-compliant data entry functionality (e.g., cloning)
Questions About Setting the Table?

Section-by-Section Analysis of the H&P

This needs to be simple enough that even a doctor can do it!
Type (and Place) of Service

- CPT now lists >40 categories of E/M services
  - Each with unique descriptors
- Most often work with outpatient visits
  - Initial Visit
  - Established Patient Visit
  - (soon to be extinct) Consultation **
- Inpatient care also common
  - Admission
  - Subsequent care
  - (soon to be extinct) Consultation**
- Anyone audit other TOS?
Medical History Component

- PFSH
  - Past History
  - Family History
  - Social History
- ROS
  - Review of Systems
- CC & HPI
  - Chief Complaint
  - History of Present Illness

General Qualitative History Requirements

- Extent of …history that is obtained & documented is dependent upon clinical judgment and the nature of the presenting problem(s)
- The CC, ROS, and PFSH may be listed as separate elements of history, or they may be included in the description of the history of the present illness
Hot E/M Issues: PFSH & ROS?

PFSH: Quantitative Guidelines

- “Pertinent PFSH” = documentation of at least 1 specific item from any of the 3 history areas
- “Complete PFSH”
  - Initial evaluations/consultations = documentation of at least 1 specific item from each of the 3 history areas
  - Established patient & E.D. = documentation of at least 1 specific item from 2 of the 3 history areas
PFSH: *Qualitative* Guidelines, Initial Visit

- “The ROS and/or a PFSH may be recorded by ancillary staff or on a form completed by the patient” (new or follow-up patient)
- “To document that the physician reviewed the information, there must be a notation supplementing or confirming the information recorded by others”
- *Note: for quality, liability protection, and compliance, there should be a notation supplementing all positive responses (even if obtained by the physician)*

ROS: *Quantitative* Guidelines, Initial Visit

- 14 organ systems
- No ROS = what is max level of E/M code (1 – 5)?
- Problem pertinent ROS: “Patient’s positive responses and pertinent negatives for the system related to the problem should be documented”
- Extended ROS: “Patient’s positive responses and pertinent negatives for 2-9 systems should be documented”
- Complete ROS
  - Must review at least 1 question for each of 10 or more systems
ROS: *Qualitative* Guidelines, Initial Visit

- **Complete ROS**
  - “Systems with positive or pertinent negative responses must be individually documented”
  - May not just state ‘ROS all negative’ or ‘non-contributory,’ or ‘unremarkable’
  - Complete ROS: “at least ten organ systems must be reviewed. Those systems with positive or pertinent negative responses must be individually documented. For remaining systems, a notation indicating all other systems are negative is permissible”

- What are the problems with “all others negative”?

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**Qualitative vs. Quantitative (paper or EHR)**

*Initial Visit ROS*
ROS: *Qualitative* Guidelines, Initial Visit

- May be documented under “present illness”
  - Creates greater challenge for an auditor
  - The issue of “double counting”
  - ROS vs. associated signs and symptoms: differences
    - Questions related or unrelated to HPI?
    - Is it really an inventory, or are questions focused on HPI?

ROS: *Qualitative* Guidelines, Initial Visit

The issue of “all others negative” (qualitative)
- IF at least ten organ systems were reviewed
- IF all “systems with positive &/or (all) pertinent negative responses are documented”

- The problems with this approach:
  - For compliance,
    - Many pertinent negative responses almost never documented
    - Determining what are the pertinent systems that warrant eval
  - For quality care (and liability protection)
    - Doesn’t report which other systems investigated
    - Doesn’t report which questions asked
- What problem is “all others negative” is trying to solve?
- What “solution” benefits both compliance & quality?
PFSh & ROS Summary Initial Visit

- Which factors are _quantitative_:
- Number of elements of PFSh documented
- Number of systems of ROS documented
- Which factors are _qualitative_
- Were positive responses supplemented?
- Were positive and pertinent negative responses documented for all organ systems related/pertinent to the presenting problem(s)
- What “solution” benefits both compliance & quality?

ROS: _Qualitative_ Guidelines, F/U Visits

- “A ROS and/or a PFSh obtained during an earlier encounter does not need to be re-recorded if there is evidence that the physician reviewed and updated the previous information”
  - _i.e., what time period should be addressed in the PFHS and ROS of a subsequent visit?_
  - _EHR functionality concern: copy forward of initial visit – what time period does this address?_

- Documented by
  - “describing any new ROS and/or PFSh information or noting there has been no change in the information”
  - “noting the date and location of the earlier ROS and/or PFSh”
  - How should MD ask this question??
History of Present Illness

• **Qualitative**: HPI is a chronological description of the development of the patient’s present illness from the first sign and/or symptom or from the previous encounter to the present. It includes the following elements:
  – Location, Quality, Severity, Duration, Timing, Context, Modifying factors, Associated signs and symptoms

• **Quantitative**:
  – “Brief HPI consists of 1-3 elements of the HPI”
  – “Extended HPI consists of at least 4 elements of the HPI or the status of at least 3 chronic or inactive conditions”
Hot E/M Issues: Physical Examination?

Physical Examination Component

- 1995 Guidelines
- 1997 Guidelines
  - General multi-system exam
  - Single organ system examinations
- Qualitative aspects of exam?
‘95 Exam Quantitative Guidelines

• Problem focused: 1 organ system
• Expanded problem focused: 2-7 organ systems
• Detailed: 2-7 organ systems
• Comprehensive: > 8 organ systems, or complete exam of a single organ system

Qualitative Exam Requirements
(in both ’95 & ’97 Doc Guidelines)

• “Specific abnormal and relevant negative *** findings of the affected or symptomatic body area(s) or organ system(s) should be documented. A notation of ‘abnormal’ without elaboration is insufficient”
  – Examples: chest pain, cough
Qualitative Exam Requirements
(in both ’95 & ’97 Doc Guidelines)

• “Abnormal or unexpected findings of the examination of any asymptomatic body area(s) or organ system(s) should be described”
• “A brief statement or notation indicating ‘negative’ or ‘normal’ is sufficient to document normal findings related to unaffected area(s) or asymptomatic organ system(s)”

‘95 Exam Quantitative Guidelines: What is the Meaning of the Qualitative Terms

• Problem focused: limited exam of affected body area or organ system
• Expanded problem focused: limited exam of affected body area or organ system and other symptomatic or related organ systems
• Detailed: extended exam of the affected body area(s) and other symptomatic or related organ system(s)
• Comprehensive: a general multi-system exam or complete exam of a single organ system
Inherent Coding/Audit Challenges in the ‘95 Doc Guidelines

• How to audit an extended (but < comprehensive) exam confined to a single affected organ system?

• Should exam be considered expanded if MD documents > 1 organ system, but does not document all the organ systems that are symptomatic or related to the presenting problem(s)?

• Frequently find charts coded for a “detailed exam” when there is an extended exam of only the affected body area or organ system, but only limited exam of other symptomatic or related organ systems

Inherent Audit Challenges in the ‘95 Doc Guidelines

• Although for a general multi-system exam, Doc Guidelines state only that ‘documentation should include findings about ≥ 8 organ systems,’ logically shouldn’t this include an extended exam of all of these organ systems (to be more extensive than a detailed exam)?

• Few specialties defined, or widely circulated, a description defining a “complete examination of a single organ system”
‘97 Exam Quantitative Guidelines

- **Problem focused**: 1-5 elements
- **Expanded problem focused**: 6-11 elements
- **Detailed**: 12 or more elements in ≥ 2 areas
  - Psych & ophthalmology: 9 or more elements
- **Comprehensive**:
  - General multi-system: perform all elements and document ≥ 2 elements in ≥ 9 areas/systems
  - Single organ system exams: perform all elements & document every element in each shaded box and ≥ 1 element in each unshaded box

Inherent Audit Challenges in the ‘97 Doc Guidelines

- Documenting and auditing exam elements not included in the standard single organ system exam
- How to address a comprehensive exam for female urology patient?
  - (pelvic exam not considered medically necessary in this specialty)?
- Others?
Hot E/M Issues: MDM?

MDM Hurdles in CPT & Doc Guidelines

- Subjective elements of E/M
  - **Number** of diagnoses and/or treatment options
  - **Amount** of data ordered or reviewed
- Elements not documented by physicians
  - Three types of risk
  - Separation of data ordered from treatment options
  - **Complexity** of data ordered or reviewed
- Complex calculation (2 out of 3)
CPT-Based MDM Solutions, Published in “Practical E/M”

- Subjective elements of E/M
  - Number of diagnoses and/or treatment options = (1 - >4)
  - Amount of data ordered or reviewed (1 - >4)
- Elements not documented by physicians
  - Separate documentation areas for management options and data ordered
  - Documentation section and guidance for subjective assessment of the 3 levels of risk and for complexity of data
- Primary option for physicians concentrating on only 2/2 subcomponents

Brief Side-trip to Non-Compliant MDM Approaches

- As a result of these MDM hurdles, plus lack of attention to the NPP, several organizations have implemented non-compliant, & clinically inappropriate, formulae for the MDM:
  - “Marshfield Clinic tool” approach
    - CMS allows individual carriers to interpret guidelines – this is not an interpretation but a re-write
  - “Trailblazer black box edits”
  - Three requirements for a valid interpretive tool
    - Gives compliant results
    - Physicians can learn and use
    - Can be incorporated into usable medical record tools
Marshfield Clinic Approach to MDM

- Changes the table of risk (violates RVUs)
- Non-compliantly blends a non-compliant level of risk with diagnoses and type of visit
  - Ignores # of treatment options
  - Distorts # of diagnoses (by inserting a max #)
  - If 1 new problem = “multiple diagnoses,” how many diagnoses are “limited” or “minimal”? 
  - For initial visits, this approach significantly overvalues relatively minor illnesses
  - For established visits, this approach significantly undervalues relatively moderate/severe illnesses

The Problem Area: # Dx and/or Rx

- Nearly every problem can be presented as a “new problem”
  - Overvalues a mild new problem
- Undervalues a worsening established problem (e.g., metastatic cancer with symptoms)
  - Ignores consideration of treatment options
- Puts limits on number of diagnoses in several of the categories
- Frequently leads to different results than CPT principles
- Fails to consider # of treatment options
- Fails to consider medical necessity!
Marshfield & the EHR Slam Dunk Level 4

- Comprehensive history
  - New Pt: pre-loaded macro, doc by exception
  - Established Pt: copy forward old history
- Detailed or comprehensive exam
  - Copy/paste pre-loaded macro, doc by exception
  - Or copy forward old exam
- Marshfield MDM
  - # diagnoses: 1 new problem
  - Risks:
    - 1 new problem with uncertain prognosis
    - 2 stable chronic illnesses
    - *Manage one prescription medication
- Ignore NPP (medical necessity)
- Time of visit & doc = 90 seconds!

Result: audit = “false claims”; liability = catastrophe; quality ↓

Marshfield & the Slam Dunk Level 4

**EDM Calculator**

- Diagnosis: [HOSPITAL ACQUIRED INFECTION (HAPI)]
  - Management Options:
    - Physical/occupational therapy
    - Physical therapy
    - Closed treatment of fracture or dislocation
    - Hand therapy
    - Physiotherapy
    - Minor surgery without risks
    - Minor surgery with risk factors
    - Major surgery without risks
    - Major surgery with risk factors
- Time of visit: 50% consultants
- Based On:
  - Office or Other Outpatient Services - ESTABLISHED
  - General Multi System
- Summary: [Prescription: [Cipro] (250mg) Tablet 100 Tablet P0 three times a day, #3 Tablet, No Refill, 2 days starting 06/30/2009; Ordered: Cipro (250mg) Tablet 250 Tablet P0 three times a day, #6 Tablet, No Refill, 3 days starting 06/30/2008; Ordered]
Trailblazer Rule Addresses Dx & Rx Well

### MEDICAL DECISION-MAKING (continued)

<table>
<thead>
<tr>
<th>A problem</th>
<th>Definition</th>
<th>Diagnoses &amp; Problem-Oriented Clinical Findings</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>A problem</td>
<td>Defined as clinical diagnosis or for recognized problems:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Each new or established problem for which the diagnosis and management plan is evident</td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>2 possible differential diagnoses, complications (or recorded from</td>
<td></td>
<td></td>
<td>2</td>
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<td>2 possible differential diagnoses, complications (or recorded from</td>
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<td>3</td>
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<tr>
<td>4 or more possible differential diagnoses, complications (or recorded from</td>
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<td>4</td>
</tr>
<tr>
<td>Total Points</td>
<td></td>
<td></td>
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### MANAGEMENT OPTIONS

<table>
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<tr>
<th>Important Note</th>
<th>These tables are not all-inclusive. The entries on examples:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do not count as treatment order’s work order such as:</td>
<td>Common “therapy” or “no change” in therapy (including drug management) specified therapy is not described (record does not document what the current therapy is) or that the physician reviewed it.</td>
</tr>
<tr>
<td>3 new or current medications per month</td>
<td>1</td>
</tr>
<tr>
<td>3 new or current medications per problem</td>
<td>2</td>
</tr>
<tr>
<td>Physical, occupational or speech therapy or other rehabilitative</td>
<td>1</td>
</tr>
<tr>
<td>Physiatric treatment or physical therapy or other rehabilitative</td>
<td>1</td>
</tr>
<tr>
<td>IV fluid or fluid component replacement, or establish IV access when record states that</td>
<td>1</td>
</tr>
<tr>
<td>Complex medical-adjunctive care, such as or/and or other complex 11</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
</tr>
</tbody>
</table>

### Education for MDM in EHRs

- Specific & educational audit reports
- Solutions for software impediments
  - Provide separation of data ordered from treatment options
  - Use graphic and narrative interface elements appropriately
- Provide for documentation of complexity of data reviewed/ordered
- Provide for documentation of three levels of risk*
- Elimination of non-compliant coding functionality
- Implementation of designs that
  - Guide appropriate MDM levels for every visit (based on NPP)
- Review with MDs the role of MDM in supporting appropriate levels of care & providing a roadmap for diagnosis & treatment

ASA, LLC
Necessity Differs from “Key Components”

Medical Necessity for Evaluation and Management Services

1. Federal law requires that all expenses paid by Medicare, including expenses for Evaluation and Management (E/M) services, are “medically reasonable and necessary.”
   * Medical necessity of E/M services is generally expressed in two ways: frequency of services and intensity of service (CPT level).
   * Medicare’s determination of medical necessity is separate from its determination that the E/M service was rendered as billed.
   * Medicare determines medical necessity largely through the experience and judgment of clinician coders along with the limited tools provided in CPT and by CMS.
   * At audit, Medicare will deny or downcode E/M services that, in its judgment, exceed the patient’s documented needs.

2. Information used by Medicare is contained within the medical record documentation of history, examination and medical decision-making. Medical necessity of E/M services is based on the following attributes of the service that affected the physician’s documented work:
   * Number, acuity and severity/duration of problems addressed through history, physical and medical decision-making.
   * The context of the encounter among all other services previously rendered for the same problem.
   * Complexity of documented comorbidities that dearly influenced physician work.
   * Physical scope encompassed by the problems (number of physical systems affected by the problems).
Medical Necessity – MCM 30.6.1 A

• Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code.
• It would not be medically necessary or appropriate to bill a higher level of E/M service when a lower level of service is warranted.
• The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported.
• The service should be documented during, or as soon as practicable after it is provided in order to maintain an accurate medical record.

Question ???

• Can you have a compliant electronic H&P without software that incorporates consideration of medical necessity?
Problems for Auditors in Electronic Records

• Physicians do not document level of NPP
• Physicians have not been taught the role of medical necessity / NPP in compliance and care
  – Though they understand it from training
• Auditors must attempt to assess clinical information to interpret severity of illness

Auditors’ Medical Necessity Challenges

• Charts lack documentation of nature of the presenting problem(s)
• How can Auditors make judgments of the level of the NPP?
  – When not documented, or
  – For confirmation when the NPP is documented?
• Use the overall sense of the record, with added focus on:
Auditors’ Medical Necessity Challenges

- Diagnosis may help IF qualifying descriptors present (e.g., severe, critical, life-threatening)
  - (usually not the CC); examples
- Data ordered & treatment options give a reasonable insight into the physician’s impression of severity of the patient’s illness
  - “Return prn” tends to indicate low NPP
  - Hospitalization, surgery, and complex evaluations tend to indicate moderate to high NPP

Solution: NPP
Error Proofing

- Documentation of NPP required to activate documentation and coding guidance for exam and MDM
- Chart should not be completed until final assessment of NPP is documented
- Failure to document NPP gives warning that chart is not audit protected
Hot E/M Issues: Time-Based Visits?

Time-Based Visits: Counseling & Coordination of Care

- Percentage of visit devoted to C&C
- Total time of visit (face-to-face for outpatient; floor time for in-patient)
- Documenting C&C care provided
Visits Where Time May Be Determinative

- **Required** elements of E/M are “relaxed” (to 0)
- 3 basic criteria must be documented:
- □ > 50% of visit devoted to counseling &/or coord of care
- ____ Total (face to face) time of visit
- Description of the counseling &/or coordination of care

Part 2: Auditors’ Tool Kit
Creating an Auditors’ Tool Kit for Reviewing EHR Documentation

• Primary resources
  – CPT
  – Documentation Guidelines
  – “Practical E/M”
  – ICD9
  – Core CPT compliance rules

• Secondary resources???
• CMS Carriers’ Manual (+ and -)
• Carrier audit tools
  – “Marshfield Tool”
  – “Trailblazer Tool”
• How should we evaluate / use these non-sanctioned tools?
  – Three requirements for short-cut tools
  – When to hold ‘em, when to fold ‘em?
**Fundamental E/M Audit Postulates 1**

If care **was not documented** in the medical record, it **was not done**

– (CMS Carriers’ Manual, section 7103.1(I))

**Fundamental E/M Audit Postulates 2**

- “Medical necessity of a service is the **overarching criterion** for payment in addition to the individual requirements of a CPT code”
  – Medicare Claims Processing Manual, Chapter 12, section 30.6.1

- **In accordance with the Social Security Law, Medicare will not pay for services that are not medically necessary**
  – Soc. Sec. section 1862
Fundamental E/M Audit Postulates 3

Automation is NOT documentation!

The FLIP Side: Fundamental E/M Education Postulates

- When care is documented in the medical record, it was done
- Medicare will pay for services that are medically necessary
  - (and were performed & documented)
- Effective documentation tools promote good documentation, so automation becomes undesirable & unnecessary
NPP as an Integral Component of E/M Audits \textit{(Practical E/M)}

- The Nature of Presenting Problems establishes the level of care that is medically necessary / warranted / medically indicated
- As conveyed in CPT Appendix C:
  - NPP identifies level of E/M care warranted by nature of problem
    - Correlated with E/M descriptors for that level of care
    - This is maximum level of indicated care, regardless of amount of documentation of 3 key components

---

\textit{Conventional} Approach to E/M Audits

- Compare documentation to coding
- Is case over-coded or under-documented?
- Only consider medical necessity if documentation in fact supports code submitted (otherwise ignored)
  - (uncommon due to failure of conventional physician approach)
    - Only apply medical necessity to \underline{lower} the code
      - Examples?
- The problem with this approach for \underline{internal} audits?
  - Examples?
**Practical E/M Approach to E/M Audits**

- Compare level of documentation, coding, and level of care warranted by the NPP
- **Step 1:** Compare code submitted to level for NPP
  - Code submitted > warranted by NPP = over coding
  - Code submitted < warranted by NPP = under coding
- **Step 2:** Compare documentation to code submitted
  - Level of documentation < code submitted (and/or warranted by NPP) = under documentation
  - Level of documentation > code submitted = irrelevant
    - Driven by physician judgment, not coding game
    - Sometimes need a little more care to rule out serious illness
    - (*error on handout: says < instead of >)*

---

**Internal “Practical E/M” Audits**

- **Phase 1:** Is E/M selected appropriate for nature of presenting problem(s)?
- Apply “Goldilocks” methodology:
  - Not too high,
  - Not too low,
  - But “Just Right”
- Resolves the question of “over-coding” vs. “under-documenting”
Sample Educational Audit Form

### Practical E/M Audit Form: Initial Outpatient Visit (p.1)

**Medical History Review**

Select the level corresponding to lowest of the components

<table>
<thead>
<tr>
<th>Level of History</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive</td>
</tr>
<tr>
<td>Detailed</td>
</tr>
<tr>
<td>Expanded</td>
</tr>
<tr>
<td>Prob Focused</td>
</tr>
<tr>
<td>No history</td>
</tr>
</tbody>
</table>

#### Level of History:

<table>
<thead>
<tr>
<th>E/M level</th>
<th>Related</th>
<th>12345</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>3 elements</td>
<td>10 or more</td>
</tr>
<tr>
<td>4</td>
<td>1 element</td>
<td>2-3 syst</td>
</tr>
<tr>
<td>3</td>
<td>0 elements</td>
<td>1 system</td>
</tr>
<tr>
<td>2</td>
<td>0 systems</td>
<td>1.3 syst</td>
</tr>
<tr>
<td>1</td>
<td>0 elements</td>
<td>0 systems</td>
</tr>
</tbody>
</table>

#### Chronology:

- ☐ Fails to document or clearly infer a chief complaint
- ☐ Fails to document supplemental details of positive findings for PFSH
- ☐ Fails to document supplemental details of positive findings for ROS
- ☐ Fails to document chronological details of HPI (performing only an "extended" Chief Complaint)
- ☐ "EHR documentation compliance issues fail to validate medical necessity & that care was performed
- ☐ Copy forward functionality
- ☐ Copy-paste of pre-loaded generic text
- ☐ Documentation by exception, automated or single click
- ☐ Impros documentation resulting from use of pick lists

Note: The blue lines indicate the E/M code submitted; they pass through the levels of care that must be performed and documented to support this level of care.

---

### Sample Educational Audit Form: 1997 Exam Guidelines

**Physical Exam Review (1997 Guidelines)**

Select the level corresponding to guideline description

<table>
<thead>
<tr>
<th>Level of Exam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive</td>
</tr>
<tr>
<td>Detailed</td>
</tr>
<tr>
<td>Expanded</td>
</tr>
<tr>
<td>Prob Focused</td>
</tr>
<tr>
<td>No exam</td>
</tr>
</tbody>
</table>

#### Level of Exam:

<table>
<thead>
<tr>
<th>E/M level</th>
<th>Related</th>
<th>12345</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>2 in each of 9 systems</td>
<td>all major, one in each minor</td>
</tr>
<tr>
<td>4</td>
<td>1-12 elements</td>
<td>1-12 elements</td>
</tr>
<tr>
<td>3</td>
<td>0.11 elements</td>
<td>0.11 elements</td>
</tr>
<tr>
<td>2</td>
<td>0.11 elements</td>
<td>0.11 elements</td>
</tr>
<tr>
<td>1</td>
<td>0.11 elements</td>
<td>0.11 elements</td>
</tr>
</tbody>
</table>

- ☐ Fails to document specific abnormal findings
- ☐ Fails to document relevant negative findings of symptomatic organ systems
- ☐ EHR documentation compliance issues fail to validate medical necessity & that care was performed
- ☐ Copy forward functionality
- ☐ Copy-paste of pre-loaded generic text
- ☐ Documentation by exception, automated or single click
- ☐ Impros documentation resulting from use of pick lists

Note: The blue lines indicate the E/M code submitted; they pass through the levels of care that must be performed and documented to support this level of care.
### Sample Educational Audit Form: 1995 Exam Guidelines

**Physical Exam Review (1995 Guidelines)**

Select the level corresponding to guideline description

<table>
<thead>
<tr>
<th>Related</th>
<th>E/M Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>4</td>
<td>8 organ systems or complete specialty specific exam</td>
</tr>
<tr>
<td>4</td>
<td>3</td>
<td>Extended exam of affected &amp; related areas/systems</td>
</tr>
<tr>
<td>3</td>
<td>2</td>
<td>Limited exam of affected &amp; related areas/systems</td>
</tr>
<tr>
<td>2</td>
<td>1</td>
<td>Limited exam of affected body area or organ system</td>
</tr>
</tbody>
</table>

Note: The blue lines indicate the E/M code submitted; they pass through the levels of care that must be performed and documented to support this level of care.

### Sample Educational Audit Form: MDM

**Medical Decision Making (MDM)**

Select the 2nd lowest of the RED circled levels

<table>
<thead>
<tr>
<th>Related</th>
<th>E/M Level</th>
<th>Dx or Rx Options</th>
<th>Data Review &amp; Ordered</th>
<th>Levels of Risk</th>
<th>Level of MDM</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>4</td>
<td>ext d ext d ext d</td>
<td>high high high</td>
<td>High</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>3</td>
<td>ext d ext d ext d</td>
<td>med med med</td>
<td>Med</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>2</td>
<td>min 1 min 1 min 1</td>
<td>low low low</td>
<td>Low</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>1</td>
<td>min 1 min 1 min 1</td>
<td>no MDM</td>
<td>No MDM</td>
<td></td>
</tr>
</tbody>
</table>

*Indicates sub-component(s) of MDM that were not documented in the medical record

**Interpretation:**

1. Level of each MDM component is circled in blue or black ink whether documented or interpreted by reviewer
2. Highest level in each of the three sections is circled in red ink
3. An asterisk within the circle of any sub-component indicates that it was not documented in the medical record
4. The calculated level of MDM corresponds to the 2nd lowest of the red circles, which appears in the final column

Note: The blue lines indicate the E/M code submitted; they pass through the levels of care that must be performed and documented to support this level of care.
Sample Educational Audit Form: NPP

Nature of the Presenting Problem(s)

<table>
<thead>
<tr>
<th>Code Level</th>
<th>Moderate-High or High</th>
<th>Moderate-High</th>
<th>Moderate</th>
<th>Low Moderate</th>
<th>Low</th>
<th>Minor</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Indicates severity of NPP is not documented in the medical record

Interpretation:
1) Circles indicate severity of NPP and level of code warranted by this degree of severity
2) If severity of NPP not documented in medical record, level of severity and corresponding level of warranted care seem appropriate based on remaining documentation, indicated by asterisk (*)
3) If appropriate severity seems to be “moderate to high,” choice of code level 4 or 5 based on level of care suggested as appropriate by the examples in CPT’s Appendix C and/or highest documented level of risk

Sample Educational Audit Form: Time

Time for Counseling / Coordination of Care

- [ ] DOCUMENTATION that > 50% of face-to-face time spent counseling and/or coordinating care
- [ ] DOCUMENTATION of total amount of FACE-TO-FACE time of visit
- [ ] DOCUMENTATION of counseling and/or coordination performed

Initial Visit | Code Level Indicated by Time
--- | ---
60 mins | 99205
45 mins | 99204
30 mins | 99203
20 mins | 99202
10 mins | 99201

Interpretation:
1) Time considered for code selection ONLY IF ALL THREE of the above boxes are checked
2) Time value selected must equal or exceed amount in selected box
Note: The blue lines indicate the E/M code submitted; they pass through the levels of care that must be performed and documented to support this level of care
Questions About Auditors’ Tool Kit?
Part 2: Auditors’ Tool Kit

Part 3: Auditing Marginal and Non-Compliant Documentation Functionality
EHR Benefits

- Legibility no longer an issue
- Faster turn around for the provider (??)
- More complete record availability
- Ease to pull previous information in such as lab results and medications
- Ease of duplication/copying or transmittal to other providers
- Data gathering if set up and used correctly

EHR Challenges and Obstacles

- Problems center on data entry into H&P
- Record cloning is problematic
- High increase in error rates found on auditing
  - Patient information mix up (i.e., genders…)
  - Conflicting information (templates / cut and paste)
  - Easy to upcode E/M and potentially falsify the medical record without realization of participating or the consequences
- When evaluating an EHR, it must be the truth and nothing but the truth!
**Data Entry Issues:** the Patient, MD, & Computer at the Point of Care

- Brief history of type of data entry allowed by EHRs
  - Type type type
  - Pick Lists
  - Dictation / voice recognition software
  - Documentation shortcuts
- What’s been missing – entry by (legible) handwriting!
  - Tablet PC
  - Digital Pen

The Problems with Typing for Data Entry
Patients Want & Expect to See This (and so should physicians)

Patients Do NOT Want This (and neither should physicians)
However, Everyone Can Be Happy with a Hybrid System!

Dictation

- Effective for individualized documentation of narrative components of H&P (if no macros)
- Not needed for sections of H&P amenable to graphic interface
- Transcription system: faster, more costly
- Voice recognition: slower, less costly
- Problems for narrative sections of H&P:
  - Many systems don’t offer dictation
  - Other systems offer dictation but also provide automated shortcuts
**Legible Handwriting**

- Effective for individualized documentation of narrative components of H&P (if no macros)
- Not needed for sections of H&P amenable to graphic interface
- Tablet PC: electronic, doesn’t save original
- Digital Pen: easy to use (for patients), saves original
- Problems for narrative sections of H&P:
  - Most systems don’t offer conversion of handwriting
  - Those that do also provide automated shortcuts

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**Attack of the Clones**

- Automated and semi-automated documentation tools result in non-individualized records:
  - Generic pick lists
  - Documentation by exception
  - Copy forward
  - Copy / paste
    - Pre-loaded generic macros
    - Copy from other charts
Generic Pick Lists

Originally offered by vendors as alternative to typing. Limited selection list of vocabulary and phrases compiled by point and shoot into a pseudo-narrative

• Fails to provide sufficient depth or breadth to encompass individual nuances and variations (needed for narrative sections and to facilitate the “art of medicine”)

What Happens When We Force a Richly Descriptive Narrative Situation Into a Pick List

• Let’s picture Will Shakespeare’s first effort at writing Hamlet, using a 200-phrase pick list:
• “Hamlet comes home from school. Father died. Mother married Father’s brother in one month.
• Hamlet disturbed. Sees ghost. Hamlet more disturbed.
• Hamlet acts crazy. Torments girlfriend (Ophelia); says “become a nun.” Ophelia disturbed, kills self.
• Hamlet kills Polonius.
• Hamlet talks to a skull (Yorick). Skull doesn’t answer.
• Rosencrantz and Gildenstern die.

• Actors visit castle. Hamlet chooses play and writes a new scene.
• Play disturbs Hamlet’s uncle. Play disturbs Hamlet’s mother. Uncle kills Mother.
• Everyone dead.
• Play ends
• {Fortunately for world literature, Shakespeare’s editor concluded pick lists are inadequate.}
Documentation by Exception

• Pre-filled graphic forms, or descriptive narratives, that physician is required to erase (if not performed) or change (from neg to pos or from normal to abnormal)
• Note: it takes more time and effort to correctly document REAL CARE with this approach that to work from a blank template, free text dictation, or writing
  – What is the problem this is trying to solve?

Copy Forward

• Moving entire blocks of history, exam, and/or MDM forward from one visit to the next
• Sequential charts appear (mostly) word-for-word identical
• Conveys patient’s status from long ago, not what has transpired since last visit
• (Leads to “care by lab tests” rather than individualized patient specific and visit specific diagnosis and treatment)
Copy / Paste

• Moving entire blocks of history, exam, and/or MDM forward from one patient to the next, or from centrally stored macros

• Potential valid uses: lab or X-ray results copied from lab section to electronic H&P – needs two clicks!

• Not reliable or compliant for history, exam, or MDM

Quality Care & Liability

Dangers of the Clones

• Leads to approaching each patient identically to every other patient in a similar diagnostic category

• Cloned (limited) diagnoses

• Cloned evaluations

• Cloned treatments

• Changes how physicians approach their patients

• Linear thinking rather than global or holistic thinking

• Physician delegates decisions to the computer
Dilbert’s Analysis of Copy & Paste

Observations on *Translation*  
(from Graphic Input to Pseudo-Narrative Presentation)

- The “Where’s Waldo” effect!
- Compliance danger that real documentation appears as if it were a pre-loaded macro with documentation by exception
- Why would a physician want to transform an easy-to-read and understand graphic interface into a 1960s style extensive transcription model record that requires more time to read and to understand ?????
Translation Example (internet)

- Translation is indistinguishable from documentation by exception
  - Auditor cannot determine if “no” responses actually asked and documented
- Loss of qualitative aspects of history
  - Impact on Compliance
  - Impact on Quality
  - Impact on Liability

---

**Past Medical History:**
Medical illnesses: Patient reports no history of diabetes, hypertension, thyroid problems. There is a history of heart disease, pulmonary problems - elevated cholesterol. There is a history of bleeding disorders, stomach or intestinal problems. There is a history of allergy problems - seasonal. There is no history of diagnoses of kidney problems, neurological problems, cancer, or other medical diagnoses.

Operations: Right knee surgery 1999 - repair lateral cruciate ligament

Medications: Ibuprofen, 400 mg as needed for pain, decongestant X pm allergy, loratadine 10 mg per day; inhaler Y pm

---

**Presenting Problems:**

- Head and Neck
  - Headaches
  - Visual changes
  - Difficulty with taste
  - Difficulty with smell
- Neck
  - Sharp
  - Pain
  - Stiffness
  - Tenderness
- Upper Extremities
  - Shoulder
  - Elbow
- Lower Extremities
  - Knee
- Chest
- Stomach
- Intestinal
- Stomach or intestinal problems
  - Allergy problems/therapy
  - Kidney problems
  - Neurological problems
  - Cancer
- Other Medical Diagnoses

---

ASA, LLC
Effect of Automation on the Diagnostic Paradigm

• Optimal Paradigm: Good Medical History Guides Dx
• Automation Paradigm: Diagnosis creates the history
  – Tentative diagnosis (based on chief complaint) generates insertion of a pre-loaded non-specific history for that diagnosis

Effect of Automation on the Diagnostic Paradigm

• As a result, the record for every patient with a given (presumed) diagnosis reads same as record for every other patient with that disease (and 2nd visit reads same as the 1st)
  – In other words: “GIGO”
  – “Every chart reads vanilla”
• Non-specific history is insufficient for precise and reliable diagnoses
Impact of Automatic Documentation on the Diagnostic Paradigm

• Increased reliance on routine laboratory and radiographic testing
• Increased costs and decreased efficiency
  – Increased “shotgun” testing
  – Increased number follow-up visits
• Decreased quality of care
  – Lost ability to recognize when test results don’t fit the history
  – Challenge when test results negative (no basis to explain symptoms or guide future care)

Questions About Issues with EHR Documentation Shortcuts?
Audit Impacts of EHR Doc Shortcuts

Effect of Automatic Documentation on E/M Compliance Audit

- Automatic defaults to negative or normal (*doc by exception*) = **FAIL**
- Details of PFSH & ROS positive responses not documented = **FAIL**
- Similar documentation visit after visit and case after case (*copy, forward and copy/paste*) shows only that EHR can enter the same macro over & over = **FAIL**
Conventional EHR Design & Compliance Risks

- Note: EMRs have not solved E/M compliance challenges; see Part B News 5/1/06
  - “The potential of such upcoding (by EMR software) has attracted the government’s attention”
  - “EMR software…may lead them to ‘select & bill for higher level E/M codes than medically reasonable & necessary’”

Reports on Compliance Problems

- CCHIT certification fails to protect against these problems
  - Only 6 total criteria for “operability” (eg, ‘be able to record encounter’)
- 2007 HHS & ONCHIT white paper: “These tools [defaults, templates, copying] can be extremely helpful if used correctly; however, the tools can also open the EHR-S up to fraud or abuse.”
  - Options for addressing these functionality problems:
    - HHS: software auditing program
    - AHCAE: eliminate flawed systems, or
    - Red flag warnings in software
Recommendations from the ONCHIT Report

• Guidelines should be developed for both vendors and users of EHRs regarding the appropriate use of documentation techniques to ensure complete, accurate, and quality documentation

Other Audit Issues Raised in ONCHIT Report

• Proxy authorship
  – Must retain date/time/user stamp of original data entry person when this will subsequently be signed by a provider
• Updates after signature:
  – Must retain copy of original document
  – Any updates after signature treated as amendments
• Auditors must have (read-only) access to EHR
How EHRs Can Over-Code without Physician “Guidance”

- 2007 White Paper: “Prompts that are driven by E&M administrative processes shall not explicitly or implicitly direct a user to add documentation.” *

- Most systems avoid this issue by simply pre-loading a shortcut with a comprehensive history and a comprehensive examination
  - Others add a non-compliant MDM tool to ensure at least moderate MDM (level 4) with only “1 new problem”

**This does not apply to prompts for additional documentation for E&M levels already achieved, for medical necessity, or for quality guidelines/clinical decision support”

“The Perfect Storm”
Federal Audits of Practices with EHRs

- Medical Economics, April 09
  - 4 practices audited after implementing EHRs and using them as instructed and intended
  - Audit failures ranged from 20% to 95% of charts
  - Fines ranged from $50,000 to $175,000+ per physician
  - Non-compliant documentation is also a “canary in the coal mine” for problems with data integrity, liability protection, and quality of care
Lessons from “The Perfect Storm”

• “Stakeholders must structure an environment where:
  – Physicians receive appropriate training with effective and compliant documentation tools
  – Software systems provide only compliant designs and protect against improper documentation
  – Government agencies eliminate non-compliant practices in their own organizations
  – Government agencies mandate compliant designs in the software systems they are advocating and promoting”

• “EHRs must be operable as well as interoperable”
• ARRA should require meaningful use of meaningful EHRs

Necessity Differs from “Key Components”

Medical Necessity for Evaluation and Management Services

1. Federal law requires that all expenses paid by Medicare, including expenses for Evaluation and Management (E/M) services, are “medically reasonable and necessary.”
   - Medical necessity of E/M services is generally expressed in two ways: frequency of services and intensity of service (CPT level).
   - Medicare's determination of medical necessity is separate from its determination that the E/M service was rendered as billed.
   - Medicare determines medical necessity largely through the experience and judgment of clinician coders along with the limited tools provided in CPT and by CMS.
   - At audit, Medicare will deny or downcode E/M services that, in its judgment, exceed the patient's documented needs.

2. Information used by Medicare is contained within the medical record documentation of history, examination and medical decision-making. Medical necessity of E/M services is based on the following attributes of the service that affected the physician's documented work:
   - Number, acuity and severity/duration of problems addressed through history, physical and medical decision-making.
   - The context of the encounter among all other services previously rendered for the same problem.
   - Complexity of documented comorbidities that clearly influenced physician work.
   - Physical scope encompassed by the problems (number of physical systems affected by the problem).
EHRs, Cloned Documents, & Medical Necessity

• “Cloned documentation does not meet medical necessity requirements for coverage of services rendered due to the lack of specific, individual information.
• All documentation in the medical record must be specific to the patient and her/his situation at the time of the encounter.
• Cloning of documentation is considered a misrepresentation of the medical necessity requirement for coverage of services. Identification of this type of documentation will lead to denial of services for lack of medical necessity and recoupment of all overpayments made.”
  – Eugene J. Winter, M.D., Medical Director for First Coast Service Options, Inc.

Effect of Automatic Documentation on E/M Compliance Audit

• Automatic defaults to negative or normal (doc by exception) = FAIL
• Details of PFSH & ROS positive responses not documented = FAIL
• Similar documentation visit after visit and case after case (copy forward and copy/paste) shows only that EHR can enter the same macro over & over = FAIL
Questions About Auditing EHRs with Non-Compliant Data Entry Functionality?

Part 4: Education for EHR Design & Functionality
Practical EHR Data Entry Principles

• “Automation is not Documentation”
• The absence of documentation is not the equivalent of documenting a negative response
• “Speed is not efficiency”
• Impact of “single click” options on human brain
• “The EHR must supplement physicians’ knowledge and judgment, not supplant them through automatic insertion of programmed clinical information and/or automated decisions regarding patient care”

EHRs Should Use a Structured Framework, (i.e., “template”) NOT a Pre-Loaded Macro

Pre-loaded Clinical Information

- While pre-loading a framework for compliant H&P is permissible and desirable, software MUST NOT pre-load clinically relevant medical information.
- ALL of the clinical information from each patient and each visit must be individually performed and individually documented
EHRs Should Use a Structured Framework, (i.e., “template”) NOT a Pre-Loaded Macro

- All pre-loaded clinical information shows only what your computer or word processor can print,
- NOT the care that is medically indicated (necessary),
- And NOT the care MD actually performed
- **Additionally, it may automate or restrict the actual care provided (it can change how physicians are supposed to practice)**

Education: EHR Solutions

- Graphic
- Narrative
- Compliant coding engine incl med necessity
- Documentation & care guidance based on NPP
- Effective Data Entry Tools
EHR Audit Approach #1 - Sherlock

- Obtain 5 – 10 charts per MD
  - At least 3-4 from same patient, in sequence
- In addition to conventional E/M audit, interpret patterns in documentation to identify suspicions of cloning functionality
  - No credit for cloned documentation
  - Note concerns for quality & liability
- Educational audit report

EHR Audit Approach #2 - Informed

- Preliminary assessment: audit the EHR screen designs and functionality
  - What & how coding engine “counts”
  - Forms/screens completed by patients
  - Identify shortcuts that lead to cloning
- Shadow physician(s) to observe how used, for compliance & efficiency
- Then perform the audits while being aware of the existing short-comings
- Educational audit report
Auditor’s Role

- Promote quality care in a compliance context
- Prevent compliance issues from arising
- Detect issues that do occur
- Remedy those issues

Questions About Impacts of Electronic H&P Compliance Challenges?
Questions?

thank you for your interest

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