

Is Your Electronic Health Record Putting You at Risk for a Documentation Audit?

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A group of 3 busy orthopedists attended coding education each year and did their best to accurately code and document their services. As a risk-reduction strategy, the group engaged our firm to conduct an audit to determine whether they were documenting their services properly and to provide feedback about how they could improve.

What we found was shocking to the surgeons, but all too common, as we review thousands of orthopedic visit notes every year: The same examination had been documented for all visits, with physicians stating in their notes that the examination was medically necessary. In addition, their documentation supported Current Procedural Terminology (CPT) code 99214 at every visit, with visit frequencies of 2 weeks to 4 months.

The culprit of all this sameness? The practice's electronic health record (EHR).

"Practices with EHRs often have a large volume of visit notes that look almost identical for a patient who is seen for multiple visits," explains Mary LeGrand, RN, MA, CCS-P, CPC, KarenZupko & Associates consultant and coding educator. "And that is putting physicians at higher risk of being audited or of not passing an audit."

According to LeGrand, this is because physicians are using the practice's EHR to "pull forward" the patient's previous visit note for the current visit, but failing to customize it for the current visit. The unintended consequence of this workflow efficiency is twofold:

1. It creates documentation that looks strikingly similar to, if not exactly like, the patient's last billed visit note. This is often referred to as note "cloning."
2. It creates documentation that includes a lot of unnecessary detail that, even if delivered and documented, doesn't match the medical necessity of the visit, based on the history of present illness statements.

Both of these things can come back to bite you.

Zero in on the Risk

If your practice has an EHR, it is important that you evaluate whether certain workflow efficiency features are putting the practice at risk. You do not necessarily need to dump the EHR, but you may need to take action to reduce the risk of using these features.

In a pre-EHR practice, physicians began each visit with a blank piece of paper or dictated the entire visit. Then along came EHR vendors who, in an effort to make things easier and

more efficient, created visit templates and the ability to "pull forward" the last visit note and use it as a basis for the current visit. The intention was always that physicians would modify it based on the current visit. But the reality is that physicians are busy, editing is time-consuming, and the unintended consequence is cloning.

"If you pull in unnecessary history or exam information from a previous visit that's not relevant to the current visit, you can get dinged in an audit for not customizing the note to the patient's specific presenting complaint," LeGrand explains, "or, for attempting to bill a higher-level code by unintentionally padding the note with irrelevant information. What is documented for 'reference' has to be separated from what can be used to select the level of service."

Your first documentation risk-reduction strategy is to review notes and look for signs of cloning.

LeGrand explains that a practice may be predisposed to cloning simply because of the way the EHR templates and workflow were set up when the system was implemented. "But," she says, "the EHR made me do it' defense won't hold water, because it's still the physician's responsibility to customize or remove the information from templates and make the note unique to the visit."

Yes, physician time is precious. But the reality is that the onus is on the physician to integrate EHR features with clinic workflow and to follow documentation rules.

The second documentation risk-reduction strategy is to make sure the level of evaluation and management (E/M) service billed is supported by medical necessity, not only by documentation artifacts that were relevant to the patient in the past but irrelevant to his or her current presenting complaint or condition.

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“Medicare won’t pay for services that aren’t supported by medical necessity,” says LeGrand, “and you can’t achieve medical necessity by simply documenting additional E/M elements.”

This has always been the rule, LeGrand says. “But with the increased use of EHRs, and templates that automatically document visit elements and drive visits to a higher level of service, the Centers for Medicare & Medicaid Services [CMS] and private payers have added scrutiny to medical necessity reviews. They want to validate that higher-level visits billed indeed required a higher level of history and/or exam.”

To do this, the Office of the Inspector General (OIG) has supplemented its audit team with registered nurses. “The nurses assist certified coders by determining whether medical necessity has been met,” explains LeGrand.

Look at a patient who presents with toe pain. You take a detailed family history, conduct a review of systems (ROS), bill a high-level code, and document all the elements to support it. LeGrand explains, “There is no medical necessity to support doing an eye exam for a patient with toe pain in the absence of any other medical history, or performing a ROS to correlate an eye exam with toe pain. So, even if you do it and document it, the higher-level code won’t pass muster in an audit because the information documented is not medically necessary.”

According to LeGrand, the extent of the history and examination should be based on the presenting problem and the patient’s condition. “If an ankle sprain patient returns 2 weeks after the initial evaluation of the injury with a negative medical or surgical history, and the patient has been treated conservatively, it’s probably not necessary to conduct a ROS that includes 10 organ systems,” she says. “If your standard of care is to perform this level of service, no one will fault you for your care delivery; however, if you also choose a level of service based on this system review, without relevance to the presenting problem, and you bill a higher level of service than is supported by the nature of the presenting problem or the plan of care, the documentation probably won’t hold up in an audit where medical necessity is valued into the equation.”

On the other hand, LeGrand adds, if a patient presents to the emergency department after an automobile accident with an open fracture and other injuries, and the surgeon performs a complete ROS, the medical necessity would most likely be supported as the surgeon is preparing the patient for surgery.

Based on LeGrand’s work with practices, this distinction about medical necessity is news to many nonclinical billing staff. “They confuse medical necessity with medical decision-making, an E/M code documentation component, and incorrectly bill for a high-level visit because medical decision-making elements meet the documentation requirements—yet the code is not supported by medical necessity of the presenting problem.”

Talk with your billing team to make sure all staff members understand this critical difference. They must comprehend that the medically necessary level of service is determined by a number of clinical factors, not medical decision-making. Describe some of these clinical factors, which include, but are not limited to, chief complaint, clinical judgment, standards

of practice, acute exacerbations/onsets of medical conditions or injuries, and comorbidities.

EHR Dos and Don'ts

LeGrand recommends the following best practices for using EHR documentation features:

1 DON'T simply cut and paste from a previous note. “This is what leads to verbose notes that have little to do with the patient you are documenting,” she says. “If you don’t cut and paste, you’ll avoid the root cause of this risk.”

2 DON'T pull forward information from previous visit notes that have nothing to do with the nature of the patient's problem. “We understand that this takes extra time because physicians must review the previous note,” LeGrand says. “So if you don’t have time to review the past note, just don’t pull it forward. Start fresh with a new drop-down menu and select elements pertinent to the current visit. Or, dictate or type a note relevant to the current condition and presenting problems.”

How you choose to work this into your process will vary depending on which EHR system you use. “One surgeon I work with dictates everything because the drop-down menus and templates are cumbersome,” LeGrand says. “Some groups find it faster to use the EHR templates that they have customized. Others find their EHR’s point-and-click features most efficient for customizing quickly.”

3 DO customize your EHR visit templates if the use of templates is critical to your efficiency. “This is the most overlooked step in the EHR implementation process because it takes a fair amount of time to do,” LeGrand says. She suggests avoiding the use of multisystem examination templates created for medicine specialties altogether, and insists, “Don’t assume ‘that is how the vendor built it so we have to use it.’ Customize a template for each of your visit types so you can document in the EHR in the same fashion as when you used a paper system. Doing so will save you loads of documentation time.”

4 DO review your E/M code distribution. Generate a CPT frequency report for each physician and for the practice as a whole. Compare the data with state and national usage in orthopedics as a baseline. The American Academy of Orthopaedic Surgeon’s Code-X tool enables easy comparison of your practice’s E/M code usage with state and national data for orthopedics. Simply generate a CPT frequency report from your practice management system and enter the E/M data. Line graphs are automatically generated, making trends and patterns easy to see (Figure).

“Identify your outliers, pull charts randomly, and review the notes,” recommends LeGrand. “Make sure there is medical necessity for the level of code that’s been billed and that documentation supports it.”

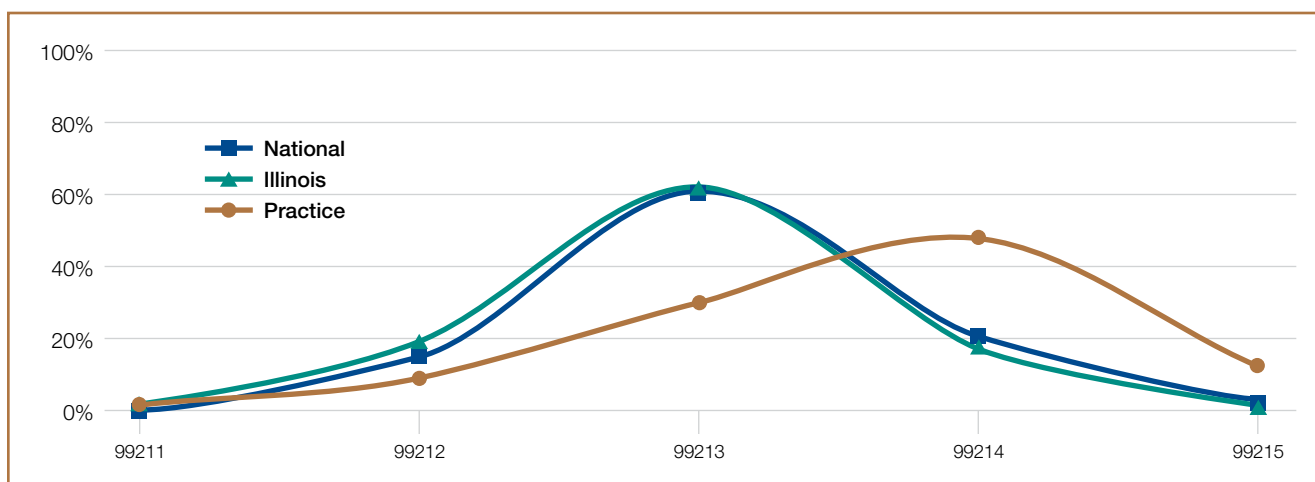


Figure. Comparing your evaluation and management code usage with state and national data can illuminate whether your coding patterns are at risk. In this example, the practice uses more level-4 and level-5 established-patient visit *Current Procedural Terminology* codes (99214 and 99215) than other orthopedists in the same state and nationally.

You may be surprised to find you are an outlier on inpatient hospital codes, or your distribution of level-2 or -3 codes varies from your practice, state, or national data. Orthopedic surgeons don't typically report high volumes of CPT codes 99204, 99205 or 99215, but if your practice does and you are an outlier, best to pay attention before someone else does.

5 DO select auditors with the right skill sets. Evaluating medical necessity in the note requires a clinical background. "If internal documentation reviews are conducted by the billing team, that's fine," LeGrand advises. "Just add a physician assistant or nurse to your internal review team. They can provide clinical oversight and review the note when necessary for medical necessity."

If you are contracting with external auditors or consultants, verify auditor credentials and skill sets to ensure they can abstract and incorporate medical necessity into the review. "Auditors must be able to do more than count elements," LeGrand

says. "They must have clinical knowledge, and expertise in orthopedics is critical. This knowledge should be used to verify that medical necessity is present in every note." LeGrand is quick to point out that not every note will be at risk, based on the amount of work performed and documented and the level of service billed. "But medical necessity must always be present."

The addition of nurses to the OIG's audit team is a big change and will refine the auditing process by adding more clinical scrutiny. The EHR documentation features are intended to improve efficiency, but only a clinician can determine and document unique visit elements and medical necessity.

Address these intersections of risk by ensuring your documentation meets medical necessity as well as E/M documentation elements. Conduct internal audits bi-annually to verify that E/M usage patterns align with peers and physician documentation is appropriate. And be sure there is clinical expertise on your audit team, whether it is internal or external. CMS now has it, and your practice should too. ■