March 16, 2018

Weekly **Auditing and Compliance** Tip

National Alliance of Medical Auditing Specialists | 877-418-5564 | namas.co | namas@namas.co

Templates for Documenting Services "The Impact of Cloning"

Click Here to Listen to This Week's Audit Tip

Ah, the ole discussion surrounding documentation and cloning... Here we are in 2018 and still documentation continues to be the Achilles' heel of medical organizations and their providers. If you were lucky enough in 2017 to avoid a payor audit, count your blessings because the level of scrutiny of provider documentation last year was beyond anything I have seen in my 22+ years of providing audit appeal defense and litigation support to our clients. In 2017, our firm was engaged in more than $170 million worth of audit refund demands and it was not limited to CMS. UnitedHealthcare, Cigna, Blue Cross Blue Shield, etc. all made demands for refunds and some of them were significant enough to impact the way we responded and will in the future, along with our approach to representing clients.

The focus on "Medical Necessity" and the required documentation to substantiate claims submitted for reimbursement has increased exponentially over previous years. No longer are payors focused solely on the elements of the History, Exam, or Medical Decision Making. They are now focused more on what you say and how you say it, rather than

focusing on the volume of documentation generated; I am referring to the "Medical Necessity" of the services. This speaks to the use of templates as well. Templates have been used even before 1988 when I started working in health care as the front desk of a multi-specialty practice in Fort Lauderdale, Florida. During the 1990s and even into the 2000s, templates continued to evolve but as they did, payor scrutiny of them increased, causing continued frustration and allowing payors to keep shifting the line on documentation requirements. Then along came the implementation of the Electronic Health Records (EHRs), with their own form of templates and their ability to allow providers to amass volumes of information on their patients whether that information was relevant and up-to-date or not.

Payors started to catch on by adjusting their types of audits to include multiple encounter dates to determine if what the providers were documenting varied from encounter to encounter, which led to the creation of the term "cloning". The Office of Inspector General (OIG) has taken a hard line when it comes to the cloning of documentation within an EHR, and "note cloning" in EHR documentation is a contentious subject in medical circles. Physicians say copying forward certain parts of previous notes can speed up documentation and should be allowed. Observers point out that although there may be no intent to defraud, overreliance on copy-and-paste can clutter visit notes with irrelevant information and make them hard to read. You can be certain the government is unlikely to relent in this matter. Several years ago, reacting to published reports that some providers were using EHRs to inflate their bills, Kathleen Sebelius, then HHS Secretary, and Eric Holder, then Attorney General, sent a letter to healthcare organizations warning them to avoid this practice. The OIG's annual reports since then show its determination to pursue this potential avenue of fraud remains despite the change in leadership.

If you are like me, I want information in terms of what I should/should not do and what I can/cannot do and the repercussions if I fail to do the right thing. So for me, I like lists of do's and don'ts - here is my short list for Templates and EHRs:

When Using Templates, DO:

1. Use templates specific to conditions or injuries to ensure it focuses on the area(s) of the patients' chief complaints
2. Make sure to use the free-text spaces/boxes to

ensure there is proper elaboration on positive pertinent patient responses

3. Have providers dictate specific anatomical areas noting defects or areas of concern especially differences from the diseased side v. the non-diseased side for surgical procedures
4. Have providers either handwrite or dictate their History of Present Illness and their Assessment and Plan for Evaluation and Management Services to ensure notes show variation from patient to patient and from encounter to encounter. Patient histories are very rarely if ever static, so the notes should not be static
5. Close out and keep updated problem lists and medication lists. Conditions that have been resolved should be removed from the active problems list as should medications that are no longer being taken by the patient. If a patient had Otitis Media 3-years ago and it resolved on antibiotics, it should not longer be on an active problem list nor should the Levaquin they took for the issue.

When Using Templates, DON'T:

1. Simply check the boxes in the Hx and Ex without elaborating on the positive pertinent and negative findings
2. Check boxes that have not been questioned or examined as a way to achieve a higher-level of service
3. Use documentation created by another provider as your own documentation (i.e., cutting the Hx or Ex out of another provider's note and plugging it into yours as a short-cut)
4. Simply go into a previous encounter note even if it was generated by you and either carry that information forward or cut and paste it into your new progress note
5. Speak in generalities for surgical interventions, since payors are demanding specifics regarding the intervention approach, type (open vs. laparoscopic), anatomical planes, anatomical differences between diseased and non-diseased sides

Following the simple steps above and remaining vigilant on ensuring your clinical documentation is thorough and complete will ensure payors one less avenue to demand refunds for services you genuinely are entitled payment for.

This Week's Audit Tip Written By:

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Sean is a Partner and the Vice President of Compliance for our parent organization, DoctorsManagement, LLC.

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Compliance in DME
(Compliance Webinar Series)
Speakers: Gene Good, JD, CPA, MAcc and Dawne Wood, AAS, CPC, CMPM, CPMN
March 19, 2018
2pm EST

MDM Of the E&M Encounter
(Hands-On Webinar Series)
Speaker: J. Paul Spencer, CPC, COC
March 27, 2018
2pm EST

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