



## NAMAS Weekly Auditing & Compliance Tips

June 3, 2016

### **Electronic Medical Records: Is Your EMR Making You Look Like a Bad Doctor?**

"As of the end of 2015, 56 percent of all U.S. office-based physicians (MD/DO) have demonstrated meaningful use of certified health IT in the Centers for Medicare and Medicaid Services (CMS) Electronic Health Record (EHR) Incentive Programs." [1]

More than half of the physicians in practice in the United States currently use some form of electronic health record to document and store their patients' medical records. While controversy still exists pertaining to the effectiveness and value of electronic medical records, there is no denying the fundamental shift in clinical documentation practices to an electronic format. There are many benefits to electronic health records (EMR/EHR) including improved legibility, access to patient records, greater ability to integrate and share electronic information across health systems and improvements to patient care through safer, more reliable prescribing practices and tracking of recommended health services for screening and prevention. There is a dark side to the use of electronic medical records however and it's critically important that physicians

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and office staff be aware and remain vigilant to some of the more common issues in documentation that may be a direct result of the use of an electronic documentation system.

### **Over-Documentation Concerns:**

EMR technology and 'click box' templates are a common shortcut allowing clinicians to record history or exam components with as little as one click of the computer mouse. The result is often a comprehensive review of systems (ROS), inclusion of a complete past, family and social history or even a comprehensive head to toe physical examination. Documentation of a comprehensive review of systems must be supported by the medical necessity of the patient's chief complaint and history of present illness. Routinely capturing a comprehensive ROS for all patient visits on every encounter strongly suggests unnecessary documentation performed simply to support the coding of a higher level of service. CMS guidelines very clearly state "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." [2]

Other concerns for EMR's with regard to history include routine use of the phrase "all others negative", "a complete review of systems is otherwise negative except as noted in the HPI", routine importing of complete past family and social history into every progress note or the use of "noncontributory" when documenting family history. Clinicians must recognize when they document a complete review of systems through phrases such as 'all others negative', they are attesting to the fact that they reviewed all 14 systems during the patient encounter. Physicians should never document services not performed - if it wasn't done, don't say that it was!

### **Documentation Inconsistent with Chief Complaint:**

CERT findings issued by regional Medicare Administrative Contractors (MACs) consistently cite a top 10 error finding for documentation not supporting the level of service reported. Medical record documentation should clearly correlate between the chief complaint, the history of



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Our second bootcamp, the **NAMAS 1-Day E/M Auditing BootCamp** breaks apart the components of E/M auditing to provide you with a better understanding. Whether you're a new auditor OR have years of experience, this bootcamp is for you! Our E/M bootcamp is scheduled in many cities across the country as well as online evenings beginning August 9!

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present illness, the extent of the exam performed and what is documented for medical decision-making. EMR templating issues that restrict or prevent providers from recording specific clinically relevant information for the history of present illness and the assessment and plan of care may result in flawed or incorrect documentation. Examples of inconsistency in the medical record include:

- Chief complaint for knee pain however a final disposition is noted for GERD.
- Chief complaint of vomiting and abdominal pain, G.I. ROS noted as negative, exam noted as unremarkable and a discharge diagnosis of acute gastroenteritis.
- Chief complaint of rash and history of present illness notes rash has been present for 'one to four weeks'. (This is a definite clinical concern - surely the physician knows more specifically if the rash has been present for a few days or for an entire month?)

**Assessment and Plan of Care is a Diagnosis List:**

EMR technology must allow a provider to record not only the condition or diagnosis but also the current status and the plan of care for treatment. CMS documentation guidelines specify the medical record should include the clinician's assessment, clinical impression, or diagnosis and medical plan of care for each patient encounter. This includes the patient's progress, response to and changes in treatment, and revision of diagnoses in the medical record.

Documentation that contains only a 'laundry-list' of diagnoses (ICD-10-CM code and description) doesn't fulfill this basic documentation requirement.

**Templated Examination Elements:**

The extent and detail of the physical examination performed is based on the providers' clinical judgment and should be relevant to the patient's chief complaint and history of present illness. Many EMR's are designed to follow examination bullet points specific to the 1997 documentation guidelines. Particularly for specialty offices such as cardiology, neurology, dermatology and ophthalmology, it's vitally important to ensure that ALL the bullet points necessary for a comprehensive examination are



**NAMAS Calendar of Events**



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**A Note from PowerBuying**



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**Upcoming Webinars**

NAMAS is proud to present the following webinars in May

included in the template. Failing to include all necessary components will result in documentation likely to never to support a comprehensive level of exam.

### **Ensuring Final Output:**

Lastly, physicians and medical office administrators should perform periodic checks of the final documentation generated by their EMR system. The clinical input view of an electronic medical record has little or no resemblance to the final output produced by the program. During compliance audits, we've had occasions when the medical record provided was incomplete or didn't support the level of service reported. It's only after the audit was completed we discovered documentation provided for the audit was a 'draft' view or some other form of temporary file within the EMR system. We've also uncovered situations where complete physician free text entries were not captured and produced in the final document. The final print output from an electronic medical record system is the medical record provided to outside clinicians, other healthcare entities and for payer/audit review. EMR systems that don't produce a complete record, consistent and containing true and valid entries into the medical record, may be responsible for documentation that reflects inappropriate or poor physician clinical standards of care. Don't let your electronic health record system make you look like a bad doctor!

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[1]Office of the National Coordinator for Health Information Technology. 'Office-based Health Care Professionals Participating in the CMS EHR Incentive Programs,' Health IT Quick-Stat #44.

[dashboard.healthit.gov/quickstats/pages/FIG-Health-Care-Professionals-EHR-Incentive-Programs.php](http://dashboard.healthit.gov/quickstats/pages/FIG-Health-Care-Professionals-EHR-Incentive-Programs.php). February 2016.

[2] Per Internet Only Manual (IOM) Medicare Claims Processing Manual, Publication 100-04, Chapter 12, section 30.6.1



### **Forensic and Compliance Risk Auditing**

Speaker: Michael Miscoe

June 7, 2016

2pm EST

### **Writing an Effective Resume**

Speaker: Carol Fox

June 14, 2016

2pm EST

### **Creating & Maintaining an Effective Compliance And Auditing Program**

Speaker: Daniel Flynn

June 21, 2016

2pm EST

### **E/M Encounter Review**

Speaker: Michelle West

June 28, 2016

2pm EST

NAMAS Members: Watch your Email for Registration Links

Non-Members: Email [namas@namas.co](mailto:namas@namas.co) to learn how to attend these webinars

**Just Released & Now Taking Pre-Orders**

**This Week's Audit Tip**  
Provided by:  
**Betty Stump, RHIT, CPC,**  
**CCS-P, CPMA**



Betty is a Senior Consultant for our parent organization, DoctorsManagement, LLC

## Join us at the NAMAS 8th Annual Auditing & Compliance Conference



**Pre-Conference:** December 6, 2016  
**Conference:** December 7-9, 2016  
**Venue:** Loews Portofino Bay Hotel  
Orlando, Florida

### [Click Here to View Conference Agenda](#)

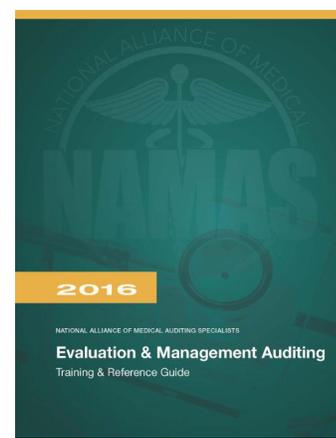
Our pre-conference is a full day of breakout sessions where attendees can choose between FOUR tracks: Physician-Based Auditing, Facility-Based Auditing, E/M Auditing with Auditors Precision Testing, and Physician-Based Compliance

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## 2016 E/M Auditing Training & Reference Guide

This manual, designed exclusively for our E/M Auditing BootCamps breaks down the components of E/M auditing, explaining topics such as history of the encounter, medical necessity, medical decision making, and grey areas of auditing policies.

This manual is ideal for both new and seasoned auditors alike.

This manual is currently in production, but we are accepting pre-orders. All pre-orders will be shipped as soon as they are available.

Click the image above for more information and to place your pre-order.

## How Compliance Hotlines Can Save Money

Written by Paul Weidenfeld

Earlier this week, we circulated an article written by Paul Weidenfeld, noted health care attorney as well as the co-founder of our partner, Exclusion Screening, LLC

In the article, Paul Weidenfeld explains how compliance hotlines can actually save your organization money.

Offer valid for new and existing NAMAS members

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Our weekly auditing & compliance tip emails are available to anyone who could benefit from this information.

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