Smoothing the Road to Medicare Audits: EHRs, Compliance, and Personnel Vulnerabilities

Maintaining thorough electronic health records may prevent costly audits.

BY RIVA LEE ASBELL

With government regulations becoming increasingly complicated, it is imperative that practices do not neglect compliance and reimbursement issues, as these areas are the most vulnerable during Medicare audits. This review concentrates on 3 main areas of concern: electronic health records (EHRs), compliance plans, and personnel issues.

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EHRs

Unfortunately, I have yet to audit a practice using EHRs where the basic programming was in compliance with the mandatory chart documentation requirements delineated in the 1997 Documentation Guidelines for Evaluation and Management Services (the 1997 Guidelines) published by the Centers for Medicare and Medicaid Services (CMS).[1] Some of the most important flaws I have seen emanate from basic programming issues, reflecting a lack of knowledge and understanding of CMS coding regulations and Office of the Inspector General (OIG) compliance mandates.

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There are 3 key components that comprise an Evaluation and Management (E/M) service: history, examination, and medical decision-making.

HISTORY

Technicians and physicians have different responsibilities in filling out the EHR. Technicians, for example, are permitted to record a patient's chief complaint, which is a brief statement of the reason for the encounter. Examples of chief complaints include follow-up for macular degeneration, blurry vision, or referrals due to other diseases (such as diabetes). However, a physician must always fill out the history of present illness (HPI). For eye codes, a simple notation of "history" is always a mandated element and thus should be performed by the physician.

Many EHR systems spew out nonsensical HPIs because the system composes its own narrative statements from drop-down menus. It is better to have the HPI entered as free text. If there is technician identification, or if the patient uses a tablet to do the HPI, the entire encounter is invalidated.

REVIEW OF SYSTEMS AND PAST FAMILY AND SOCIAL HISTORY

Technicians are permitted to do the initial intake

PROSPECTIVE VS. RETROSPECTIVE AUDITS		
	Prospective Audits	**Retrospective Audits**
Time Frame	Performed before claims are submitted for payment.	Performed after claims were paid.
Risk	Lessens exposure for qui tam (whistle-blowing) lawsuits because claims are submitted as coded by the auditor.	Increases exposure to qui tam lawsuits because staff is aware of errors.
Advantages/Disadvantages	Many attorneys prefer prospective audits in order to avoid expensive mandated paybacks.	Millions of dollars can be identified as needing payback, even in a small practice, when errors as discussed in the review exist.

on the review of systems (ROS) and past family and social history (PFSH). However, a physician must review these entries and make a notation that they have been reviewed. Initials or signature alone do not count. I have yet to see an update template or notation mechanism incorporated into any EHR system. The ROS, for coding purposes, inventories organ systems for past and present problems, very different from what physicians are taught in medical school.

EHR systems notoriously carry forward prior data that is not updated. I have yet to encounter an update notation, which would be mandatory, if history is being used as one of the elements for coding. The 1997 Guidelines mandate "when coding for established patients and using history as one of the key components, that an update notation be present."

I recommend developing a template for updating the ROS/PFSH wherein the updating person simply fills in the date or any updates. For example: "ROS/PFSH reviewed. No changes since ____" or "the following changes are noted: ____."

The ROS/PFSH is not being filled out properly in almost all EHR systems. The 1997 Guidelines specify that "A complete ROS inquires about the system(s) directly related to the problem(s) identified in the HPI plus all additional body system(s)." If an organ system is positive, then the medical problems involving that system must be described. The OIG considers a statement such as "10+ systems were reviewed, all others noncontributory" insufficient. After auditing 15 or 20 charts with a repeated notation, an auditor would wonder if patients were even asked any questions.

The physician has to notate in the chart documentation that the ROS/PFSH were reviewed and make changes and/or additions when applicable. Without that notation, the ROS/PFSH is not counted as having been performed, and the code level is severely reduced.

Any functions on the EHR system that create pre-populated charts and/or default negatives for ROS/PFSH should be turned off.

The patient's current medications, considered part of the past history, should be listed with dosages and strengths. The medications should coordinate with the disease entities in the ROS. In other words, for inventorying the endocrine system, a patient reporting use of a drug for diabetes should not be described as "negative" in the ROS.

EXAMINATION

The chart documentation for describing "mood and affect" and "oriented to time, place, and person" should be placed at the end of the documentation of examination so it is clear that these elements were performed by a physician. Any element to be counted toward the level of the examination must be performed by the physician.

The same type of chart documentation required for ROS/PFSH is required for each of the 14 examination elements. Each element must be individually noted as normal or abnormal, and, if it is abnormal, the specific abnormalities must be described. A review of the section on "Single Organ System Examination for Ophthalmology" in the 1997 Guidelines can point you toward useful and reliable nomenclature.

No examination elements performed by technicians can be counted toward the level of the visit. This applies

to both eye codes and E/M codes. Technician identification should be removed from the chart. Auditors consider any elements located above the technician's signature as performed by someone other than the physician; thus, these elements of the examination cannot be counted toward the level of coding, resulting in overcoding. The EHR only calculates how many elements were performed, not by whom, resulting in overcoding of encounters.

MEDICAL DECISION-MAKING

With the implementation of ICD-10 due on October 1, 2015, the most important parts of the chart documentation for determining medical decision-making are the order in which the diagnoses are listed and the specificity and laterality of each diagnosis. Many insurers will use the first diagnosis as the driving diagnosis for claim payment. The first diagnosis listed should reflect the purpose of the visit for that day. Inevitably, the EHR will list many diagnoses, many of which will not be viable for the retina physician to use for coding that particular encounter when they are not the ones following that problem.

AUTOMATIC CODING OF CHARTS

The results of automatic coding are rarely satisfactory or accurate. The EHR program determines only that a space has been filled out, not whether it was filled out accurately or whether there was medical necessity for the service. Thus, EHR programs tend to overcredit the final result. Automatic coding, combined with improper chart documentation, inevitably leads to refunding monies to CMS during audits.

DIAGNOSTIC TESTS

Medicare has several requirements regarding diagnostic tests. An order for each test and a corresponding physician signature must be included. Also required is an interpretation and report containing a diagnosis, comparative data, and clinical management details. Medicare requires additional separate documentation because physicians are paid separately for these tests. Thus, documentation detailing diagnosis, comparative data, and clinical management details must be located in an area distinct from the examination portion of an EHR and must be clearly labeled "Interpretation and Report." The information placed here may repeat information provided in other areas of the chart. I have seen only 1 EHR-generated report that addresses the aforementioned requirements.

There are payment and compliance problems caused by not having a separate interpretation/report for every billed test or cloning of extended ophthalmoscopy records wherein the same sketch is used for subsequent encounters. A Medicare Administrative Contractor (MAC) considers extended ophthalmoscopy chart documentation as being insufficient if it does not follow the 3 interpretation/report guidelines as noted above.

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COMPLIANCE PLANS

The Compliance Program for Individual and Small Group Physician Practices, issued by the OIG in 2002, is still in effect.[2] This voluntary compliance plan suggests that plans should contain 7 components, although all 7 components are not mandatory. Health care attorneys will inform you that if you have a compliance plan, do not follow it, and are audited, the resulting penalties will be worse than if you had no plan in place at all. A compliance plan may give physicians a false sense of security. It is important when drafting your compliance plan to keep it simple. It is always possible to modify it.

"Conducting internal monitoring and auditing" is the first component listed in the OIG document. The subject raises a serious query: If the national societies do not offer comprehensive training in the E/M codes and eye codes (which is the current situation), how qualified are internal auditors going to be? The MAC that services your state is an excellent source of information. It is wise to appoint someone to sign up for their e-mail alerts so that the practice can keep up with local coverage determinations and other guidelines and attend informative webinars and training.

An external audit performed by a disinterested third party is a useful way to ensure compliance. If you use a third party consultant, the consultant should be ophthalmology-specific. Internal auditors may be overprotective of the practice and thus not totally unbiased in their findings, whereas an external auditor should be immune to conflicts of interest.

Prospective external audits are performed before claims are submitted for payment, whereas retrospective external audits are performed after payment submission. Each type of external audit carries it own risks and rewards (Table). The advantage of a retrospective audit is that it is less burdensome to the practice, in that there is no wait to submit claims for payment. However, monies paid for charts that are determined

to be overcoded or not valid for reimbursement under a retrospective external audit must be repaid within 60 days.

PERSONNEL

Personnel are the weakest link where compliance is concerned. Billing personnel and physicians have been the source of many whistleblower lawsuits in which I have been involved. Compliance committee minutes and findings should be kept confidential. Misunderstandings in these matters often result from the plaintiff's lack of complete comprehension regarding clinical and financial issues.

A QUICK-START PROGRAM

Here are some suggestions to improve your chart documentation, make your coding compliant, and assist in easier defense during audits:

- When undergoing an external audit, be sure a critique of your EHR is included, as well as a practice assessment with recommendations for change and improvement.
- Review your compliance program and make sure it is not filled with things you have not done or cannot do. An example would be specifying monthly internal audits. Remember, the practice is worse off if it does not adhere to the provisions. Revise the program to be less onerous if necessary.
- Have a prospective rather than a retrospective external audit performed. This does not have to be on a massive scale. It will get the practice going in the right direction.
- Use original CMS or MAC source material as guidelines for all issues.
- The OIG recommends yearly audits. The goal should be getting into compliance, and then you can extend the interval as appropriate. ■

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1. 1997 Documentation Guidelines for Evaluation and Management Services. Department of Health and Human Services. http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network- MLN/MLNEdWebGuide/EMDOC.html. Accessed January 13, 2015.
2. Compliance Program for Individual and Small Group Physician Practices. Office of Inspector General, US Department of Health & Human Services. https://oig.hhs.gov/compliance/physician-education/05compliance.asp. Accessed January 13, 2015.