Effective Documentation: Strategies for Success

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What you say can and will be held against you!
What you don't say can and will be held against you!
Documentation Basics

- Paint a picture
- Write legibly
- Sign and date everything
- Reference therapy, lab results, medications and current condition
- Review and respond to consultant pharmacist med reviews
CMS on Medical Documentation

- Complete and legible
- Include legible identification of the provider
- Include legible date of service
- Clearly and permanently identify amendments, corrections or addenda
- Clearly indicate date and author of amendments, corrections and addenda
- Clearly identify all original content (do not delete)
CMS on Medical Documentation

• Signature must be legible
• If signature is missing or illegible on medical documentation (other than order) contractor considers signature log or attestation statement
• If signature is missing for order, the review contractor must disregard the order
  ▪ Attestations not allowed for orders

Department of Human Services (DHS) Documentation Requirements

• Must be legible

• Entries signed & dated by responsible licensed provider

• Alterations of record must be signed & dated

• Record shows progress at each visit, change in diagnosis, change in treatment, and response to treatment
DHS Documentation Requirements

• Progress notes must include relationship of services to treatment plan

• Records must fully disclose nature and extent of service rendered

• 55 Pa. Code 1101.51(e)
Remember Your Audience

- Surveyors
- Other regulators and enforcers
- Owners, board, co-workers, donors
- Existing residents/clients and families
- Potential residents/clients and families
- Plaintiffs’ lawyers
- Juries
- Media
Incident Reports

• Just the facts
• Confidential?
• Risk management?
• Peer review?
• Quality assurance?
• Communications to Regional Team?
Example of Documentation Errors

- MAC determined physician’s visit to SNF patient after discharge medically unnecessary because “patient has no complaint.”
  - Patient was diabetic 80 year old taking blood thinner. At risk for post-op infection.
  - Physician’s first sentence in progress note “the patient feels OK today”
  - Remainder of progress note explained visit and concerns of infection
Be Careful of E-Mails and Texts!

The “E” in E-Mail stands for

EVIDENCE

….and the “T” in Text could lead to

TESTIMONY
Be Careful of E-mails!

“...payroll costs shall NEVER EXCEED 40% of Revenue.”

“The situation is becoming critical. We do not have 50% of people we need to complete a schedule for evenings and nights. [O]n evenings I would like to have 18 people in house to care for residents, yesterday evening I had 11…and on nights whereas I would like 12 had 8. It does not get the job done. Our care is suffering…”
What keeps you up at night?
CMS Civil Money Penalty (CMP) Analytic Tool

- Surveyors look for first evidence of deficient practice to start CMPs

- **Tip:** Review 2567 carefully and prepare IDR for any factual inaccuracies
  - Once CMP is issued, amount must be escrowed if challenged

CMP Culpability Add-Ons

• Neglect, indifference, or disregard for resident care, comfort or safety
  ▪ SNF responsible and culpable for actions of its management and staff, and contract staff

• Failure to act culpability amount up to $500
  ▪ If management officials, e.g., administrator, director of nursing, facility owners, and/or the facility’s governing body knew of problems but failed to act
Hypothetical F314 Deficiency S/ S G

- Feb. 5 progress note identifies reddened area on R1 sacrum
- Feb. 12 weekly wound report identifies Stage 4 preventable pressure ulcer on R1 sacrum
- Aug. 4 survey identifies documentation error
- Surveyor interviews with DON and wound care nurse confirm that facility is unable to provide documentation that R1’s pressure ulcer was timely identified or that physician notified
- SNF assessed retroactive CMP for 212 days
New MDS and Staffing Focused Surveys

- 2-day surveys focused on MDS accuracy and staffing
- Pilot program in 5 states, 25 SNFs -- 96% error rate
  - Inaccurate staging and documentation of pressure ulcers
  - Lack of knowledge re classification of antipsychotic drugs
  - Poor coding regarding use of restraints
Focused Surveys

• Assess MDS coding practices in relation to resident care, as well as staffing levels

• OIG 2013: SNFs reported inaccurate information, not supported or consistent with medical record, on at least one MDS item for 47% of claims

• OIG 2012: 99% of assessments of residents receiving atypical antipsychotic drugs missed at least one requirement
Focused Surveys

• Look for evidence of involvement by a professional qualified in relevant care area to conduct a comprehensive assessment, such as a mental health professional

  OIG: 46% of records, RN was solely responsible for conducting resident assessment, even though residents may have had mental health conditions that needed to be assessed by qualified health professionals
Focused Surveys

• Key MDS elements correlated to accurate documentation
  ▪ Nursing notes
  ▪ Physician progress notes
  ▪ MARs
  ▪ TARs
  ▪ Care plans
  ▪ Hospice records
Can You Protect Your Internal Reviews?
The Audit & Investigation Team

- Who does your review?
- Mock surveys
- Quality reviews
- Billing reviews
Protecting Confidentiality

- Consultants – no legal privilege for reports generated independently by consultants

- Privilege may attach if outside counsel retains the consultant

- The larger the audit team, the more difficult it will be to maintain the confidentiality of the audit records and reports
Accountants and Attorneys

• Attorney-client privilege protects certain communications

• Attorneys do not have a duty to disclose misconduct (with certain minor exceptions)

• Attorney may engage consultants to assist them in providing legal advice to their clients, thereby potentially extending the attorney client privilege and attorney work product protection
Protecting Confidentiality

• Attorney related privileges may be successfully invoked if it is shown that:
  ▪ Legal advice was sought in anticipation of litigation
  ▪ Relationship was treated as confidential
  ▪ Third party investigators hired by counsel similarly treat communications in confidential manner

• Retention of outside counsel may strengthen position
Accountants and Attorneys

• No accountant “privilege” -- communications and work papers are discoverable

• Accountants have duty to disclose if they identify violations and are not satisfied by the company’s response
  - “10A” obligation to report company misconduct internally and externally if the company does not satisfactorily resolve the issue
Other Considerations

• E-mails to/from counsel
• Nursing “soft notes” and daily journals
• 24 hour reports and shift to shift logs
• Attorney bills
• Think before you put things in writing
Electronic Medical Records
Research Questions Concerns About Fraud in EMR (7/ 2014)

- Study examined hospitals with and without EMR (adopters and nonadopters)

- “No empirical evidence suggest hospitals are systematically using EHRs to increase reimbursement.”

- “A policy intervention to reduce fraud is therefore not likely to be a good use of resources.”

Cite: Julia Adler-Milstein and Ashish K. Jha, No Evidence Found That Hospitals Are Using New Electronic Health Records To Increase Medicare Reimbursements, Health Affairs, 33, no. 7 (2014): 1271-1277
[http://content.healthaffairs.org/content/33/7/1271.full.html (accessed 7/9/2104)]
OIG to CMS: Address Vulnerabilities in EMRs (1/2014)

• Provide guidance to contractors (MACs, RAs & ZPICs) on detecting fraud in EMRs

• Direct contractors to use providers’ audit logs
  ▪ Paper records give “clues” absent in EMR
    ▸ Progress notes
    ▸ Handwriting
    ▸ Attributes of authenticity

• Providers often disable or bypass usage policies and technology features
OIG to CMS: Address Vulnerabilities

• Copy-pasting/cloning/”Make Me Author”
  ▪ Inaccurate information
  ▪ Inappropriate charges
  ▪ Facilitate attempts to inflate claims or create fraudulent claims

• Overdocumentation
  ▪ False or irrelevant documentation to support higher level of service
  ▪ Checkboxes generate extensive documentation
OIG Findings: MACs & ZPICs

- Medicare Administrative Contractors (MACs) confirm electronic signatures & request EMR protocols

- Zone Program Integrity Contractors (ZPICs) request info about EMR technology and question providers about ability to access and alter EMR data

- Use audit log to verify that medical record was not changed after date of care & to validate authenticity of entries
OIG Findings

• Copy-paste language easier to identify when multiple claims are reviewed

• Contractor action when cloning/over documentation identified
  ▪ Referrals to ZPIC and law enforcement
  ▪ Provider education about proper documentation
  ▪ Denial of payment; overpayment adjustment; payment suspension
  ▪ Additional interviews, reviews or site visits
Risks of EMR

- Identical care plans
- Entries not specific to resident
- Drop down phrases, smart text
  - Ambulates freely through facility
- Phrases that could be repetitive may be especially bad for Medicare coverage
- Focus on
  - What are you assessing?
  - What did you do?
  - What is your next step?
Risks of Copy/Paste

• May prevent actual assessment of resident

• Reliance on prior information may lead to:
  ▪ Potential errors of fact
  ▪ Incomplete records
  ▪ Poor quality of care

• Potential for false claims
Risks of Auto- or Pre-Population

• Can generate extensive documentation that, if not appropriately reviewed and edited, can be inaccurate

• Can result in failure to note critical information, such as a change in condition

• Can result in inappropriate care

• Potential for false claims
OIG EMR Recommendations

• Audit logs
  ▪ Track changes chronologically
  ▪ Date, time and user stamps for each update
  ▪ Use to analyze historical patterns
  ▪ Should always be operational
  ▪ Store as long as the clinical record
  ▪ Never alter
OIG EMR Recommendations

• Access controls
  ▪ Unique IDs, passwords, and access levels
  ▪ Monitor entries “made on behalf of another”
  ▪ Create “auditor class” of users who have read-only access to EMR [surveyors]

• Provide patient access to and ability to comment within EMR
OIG EMR Recommendations

• Export controls that restrict transfer of information
  ▪ Require encryption of EMR during transmission
  ▪ Attach user ID to any EMR that is exported
  ▪ Link information transferred for claims payment to appropriate EMR

• Implement technology that alerts user of inconsistencies between documentation and coding
AHIMA Resources

- Steps to prevent falsification of EMRs
- Guidelines for selecting and implementing EMR system features to reduce the likelihood for falsification
- Fraud prevention education programs (training requirements, security and integrity requirements, violation of EMR policy and procedure consequences)
AHIMA Resources

- Recommendations for establishing a process for logging all activity on EMR systems (audits and audit trails recommended)

- Sample business rules for EMR systems

Closing Thoughts

• Document to “paint a picture” for colleagues, care team members, auditors and juries
• Monitor your own records for consistency
• Electronic medical records present risks of cloning, copying and repetition that can be detected by data analytics

• Don’t be afraid to call your health care attorney
Questions?

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