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ATTORNEYS AT LAW

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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 identify 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

CMS, "Importance of Preparing/Maintaining Legible Medical Records," MLN Matters, SE 1237 (Nov. 23, 2012).

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?

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CMS Civil Money Penalty (CMP) Analytic Tool

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

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

CMS Survey & Certification Memo, "Civil Money Penalty (CMP) Analytic Tool and Submission of CMP Tool Cases, S&C: 15-16-NH (Dec. 19, 2014)

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
- http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_050286.hcsp?dDocName=bok1_050286

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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