General Documentation Compliance

Review for Provider Reappointment
Objectives

Review the principles of compliant billing and documentation, timely medical record documentation and their importance to your practice.

Review EHR vulnerabilities and the UNC Health Care policy on copying and pasting in the electronic medical record.

Review documentation and supervision requirements for “Incident-To” encounters with an Advanced Practice Practitioners (APP).

Review documentation and supervision requirements for Shared Visits with an APP.
Compliant documentation impacts reimbursement and quality of care

Providing good care while billing accurately and confidently requires:

- Billing what is medically necessary
- Documenting what you do
- Ensuring your documentation supports the services that were performed and billed

Understanding and applying coding and compliance conventions can improve the accuracy level of reimbursement for UNC Health Care as well as the quality of the documentation in the medical record.
Why Compliance?

- **Ethics and Professionalism**: Do the right thing!

- **Community**: Uphold our reputation in the community by following laws, regulations, and UNC Health Care policy.

- **Patient Care**: Good documentation contributes to quality patient care and safety.

- **Exclusion**: Providers with frequent non-compliance or fraudulent billing / documentation practices may be excluded from participating in federal healthcare programs.

- **Government Penalties**: Fraud and false claims carry significant penalties, such as fines and imprisonment.

- **Audits and Overpayment Collection**

During the first half of FY 2016:

- The OIG reported expected recoveries of more than $2.77 billion, from 428 criminal actions against individuals or entities and 383 civil actions in addition to lawsuits and Civil Monetary Penalties (CMP) settlements and self disclosure administrative recoveries.

- The OIG also reported exclusions of 1,662 individuals and entities from participation in Federal health care programs during these 6 months.

CMP recoveries have increased almost five fold over the past 3 years.
Recent changes in the federal law increase provider liability

- **False Claims Act**: Treble (triple) damages, plus $10,781.40 to $21,562.80 *per claim* (per Bipartisan Budget Act of 2015)

- **60 day repayment rule** (per Affordable Care Act)
  - Providers must pay back overpayments within 60 days of identification, regardless of the cause of the overpayment. Failure to make a timely refund can be grounds for a False Claims Act violation.

- **Six year look back period** (per Affordable Care Act)
  - The obligation to refund, particularly when the overpayment is systemic, can go back six years.

- Changes from the Affordable Care Act have lowered the standard required for the government to prove a violation.
Yates Memo changes compliance enforcement to “individual accountability” in addition to corporate accountability

“Individual Accountability for Corporate Wrongdoing”  Dept of Justice (DOJ), Sept 9, 2015

- Prosecutors can no longer recommend that the organization receive “credit” in the form of reduced penalties unless the organization turns over all information on *everybody* that may have participated in wrongdoing.

- Prosecutors are required to prosecute all individual employees where there is sufficient evidence to do so.

- In the past, the DOJ had generally not pursued actual prosecutions against individuals except in egregious instances of fraudulent or corrupt conduct. The Yates memo changed this enforcement policy to make all individuals involved accountable.

Recent news: Toumey CEO pays $1M over settlement; North American Health Care Board Chair pays $1M, Senior VP $500K
Non-compliance may lead to audits and overpayments

- Providers are subject to a variety of audits by Medicare contractors and third parties, including Recovery Audit Contractors (RACs).

**Overpayments (in Millions) collected by Recovery Audit Contractor for Region C**

![Graph showing overpayments from FY10 to FY14](https://www.cms.gov/research-statistics-data-and-systems/monitoring-programs/medicare-ffs-compliance-programs/recovery-audit-program/)

- RAC overpayment corrections in our region rose from $24.4 million in FY10 to **$1.13 billion** in FY14
- In FY14, $82.5 million in overpayments were collected in North Carolina
- UNCH has paid $375K in RAC overpayment corrections in FY16
Four North Carolina Hospitals Were Overpaid $1.86 Million

Errors included admissions that should have been billed as outpatient or observation services and incorrectly billed DRG codes. Errors were made on 73 of 225 audited claims.

October 2015: United States Resolves $237 Million False Claims Act Judgment against South Carolina Hospital that Made Illegal Payments to Referring Physicians
July 2016: University of Pittsburgh Medical Center paid $2.5 million to settle false claims for billed for surgeries in which some of its doctors acted as first assistants or teaching assistants. The lawsuit claimed UPMC billed for the assistant services when those doctors did not meet the criteria or were not present at all.

Hospital Bills for Evaluation and Management (E/M) Services at Higher Levels Than Justified by Medical Records
An oncologist generated a disproportionate number of CPT code level 5 visits. A chart review concluded the oncologist was billing CPT code 99214 or 99215 when lower-level codes were appropriate.
Timely Completion of Medical Record Documentation
Timely documentation means at the time services are rendered

- All services provided to beneficiaries are expected to be documented in the medical record at the time they are rendered. Occasionally, certain entries related to services provided are not properly documented. In this event, the documentation will need to be amended, corrected, or entered after rendering the service. – Medicare Program Integrity Manual, Chapter 3; Section 3.3.2.5

- For hospital medical completion policy requirements please refer to your specific hospital medical staff bylaws and policies.

  - Example: UNC Medical Center’s Medical Record Completion Policy (Admin 0096) states that all records must be completed within 28 days of the date of discharge.
Copying and Pasting and Data Replication in Electronic Documentation
Electronic Health Record documentation can cause vulnerabilities for you and UNC

Altering notes improperly may undermine the integrity of the electronic health record (EHR) and jeopardize reimbursement and patient safety.

- Medicare does allow documentation changes within limits, including amendments, corrections, addenda, and delayed entries if they are clearly identified and there is no tampering with original content.

Both the Office of Inspector General (OIG) and the Department of Justice (DOJ) have warned about misuse of EHRs. Potential problems include:

- Copy/Paste
- Pull Forward
- Note Bloat
- Medical Plagiarism
- Make Me the Author
“Make Me the Author” functionality can lead to claim denials or fraud

Specific ways EHRs can lead to claim denials or fraud:

“Make me an author” tool

- Allows a provider to substitute their signature for that of another person who entered notes in the EHR.
- The tool is particularly problematic if physicians become the author of medical student notes.
  - Per Transmittal 1780, Medicare limits medical student documentation to Past, Family and Social History and the Review of Systems; all other documentation must be verified and **RE-DOCUMENTED** by the physician.
- The tool does not replace the attestation requirement for a Teaching Physician working with a Resident physician as it does not support the documentation by the Teaching Physician of their face-to-face involvement with the patient during the patient encounter.
Carefully inspect and edit notes when using copy/paste and carry forward functionality

Templates

- Auto-populating tools and drop down menus may multiply the effect of an incorrect piece of data and may also contribute to the inappropriate up coding of an encounter.

Copy/Paste or Cloning

- Cloning occurs when an entry in the EHR is worded the exact same way or is very similar to previous entries.
- When entries are copied and pasted without being edited, medical necessity is not established because the documentation isn’t specific to the current patient encounter.
- Patient care could be compromised if old treatment plans are copied and pasted.
The EHR can facilitate good documentation, but can also be misused

American College of Physicians Position Paper: “None of these options for documentation [such as templates, drop-down boxes, macros, and the copy/paste function] is inherently inappropriate, but each can be intentionally or unintentionally misused.”

- The clinical record should include the patient's story in as much detail as is required to retell the story.
- Macros and templates may be valuable in improving the completeness and efficiency of documentation.
- The EHR should facilitate thoughtful review of previously documented clinical information.
- Where previously documented clinical information is still accurate and adds value…, this process of “review/edit and/or attest, and then copy/forward” of specific prior history or findings may improve the accuracy, completeness, and efficiency of documentation.
- However, these documentation techniques can also be misused, to the detriment of accuracy, high-quality care, and patient safety.
In the popular press as well...

Cloning notes in electronic health records (EHRs) has drawn criticism from a top government report, calling the practice fraud. However, those in the medical field have complained for years that lack of time and poorly designed systems are the real reasons for billing mistakes.

A report by the Department of Health and Human Services Office of the Inspector General (OIG) calls out the Centers for Medicare and Medicaid Services (CMS) for failing to implement measures to prevent fraud. The New York Times reported last week that the federal government’s $27 billion program launched in 2009 to encourage EHR use in practices and hospitals may have suffered from “hundreds of millions of dollars” of fraudulent activity.

The New York Times

Report Finds More Flaws in Digitizing Patient Files

Although the federal government is spending more than $22 billion to encourage hospitals and doctors to adopt electronic health records, it has failed to put safeguards in place to prevent the technology from being used for inflating costs and overbilling, according to a new report by a federal oversight agency.

The report, released on Wednesday by the Office of the Inspector General for the Health and Human Services Department, is the second in two months to warn about flaws in the oversight of the ambitious federal program aimed at converting patient records from paper to electronic. It
One argument: Control copy & paste to combat “note bloat”

**Drowning in note bloat?**

One hospital’s new progress note stops the flood of auto-generated data

Keywords: Hospitalists work to cut bloated EHR notes

by Phyllis Maguire

*Published in the October 2014 issue of Today’s Hospitalist*

**ONE THING** you have to give to electronic health records (EHRs): They’ve made physician notes legible.

Unfortunately, they’ve also allowed doctors to produce a staggering amount of auto-generated data that can render physician notes close to useless. As such, note bloat and other electronic documentation hazards—like copy and paste, and copy forward—threaten both patient safety and physician liability.
Uncle Sam steps into the copy/paste discussion

Access tends to be one of the last features a hospital implements after focusing on initiating other EHR functions.

**Only about one quarter of hospitals had policies regarding the use of the copy-paste feature in EHR technology**

Although the copy-paste feature in EHRs can enhance efficiency of data entry, it may also facilitate attempts to inflate, duplicate, or create fraudulent health care claims. RTI acknowledges the potential for misuse of the copy-paste feature in EHRs and suggests that specific warnings directed to EHR users be considered. Further, RTI recommends that the

**Not all recommended fraud safeguards have been implemented in hospital EHR technology**

Opportunities for a provider to inappropriately copy-paste language and overdocument in a medical record for higher payment exist in paper medical records as well as EHRs. However, features in EHR technology make it easier for providers to copy-paste and overdocument in EHRs.

**Table 2: Number of CMS Contractors That Reported Being Able To Identify Copied Language and Overdocumentation**

<table>
<thead>
<tr>
<th>Type of Contractor</th>
<th>Copied Language</th>
<th>Overdocumentation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>EHR</td>
<td>Paper Medical Record</td>
</tr>
<tr>
<td>MAC</td>
<td>4 out of 8</td>
<td>4 out of 8</td>
</tr>
<tr>
<td>ZPIC</td>
<td>3 out of 6</td>
<td>6 out of 6</td>
</tr>
<tr>
<td>RAC</td>
<td>2 out of 4</td>
<td>1 out of 4</td>
</tr>
</tbody>
</table>

Source: OIG analysis of contractors’ responses to questionnaire, 2013.
Copy/Paste is on our local Medicare carrier’s radar

Medical Record Cloning *(Palmetto GBA Updated 10/31/14)*

The word 'cloning' refers to documentation that is worded exactly like previous entries. This may also be referred to as 'cut and paste' or 'carried forward.' Cloned documentation may be handwritten, but generally occurs when using a preprinted template or an Electronic Health Record (EHR).

While these methods of documenting are acceptable, it would not be expected the same patient had the same exact problem, symptoms, and required the exact same treatment or the same patient had the same problem/situation on every encounter.

*Cloned documentation does not meet medical necessity requirements for coverage of services. Identification of this type of documentation will lead to denial of services for lack of medical necessity and recoupment of all overpayments made.*
UNCHCS’ Copy Paste Policy reflects both the usefulness and potential risk:

- Summarizing findings and medical judgement is encouraged for lab data, pathology, and radiology reports rather than copying such reports in their entirety into the note, when possible.

- The note should include only that data which supports the impression and plan.

- Attending physicians are encouraged to carefully review each note for content and to provide feedback to trainees.

- **Do not copy notes written by students**
  - Only the student’s Review of Systems and Past Medical, Family, and Social history documentation may be used to support a billable service per government regulation.
Tips to avoid re-entering documentation

For physical exams performed that were identical in scope and findings, make a statement in the current note:

- “Same exam performed as on 1/15/15 with same findings as below.”

You may refer to material reviewed in EPIC instead of entering specific detail into the note:

- “Medication list and medical history reviewed”
- “Patient intake form reviewed and initialed with today’s date, all systems other than those in HPI are negative.”
Use of scribes have specific requirements

Scribes **MAY NOT:**
- Provide any clinical care to patients
- Interject their own observations, impressions or recommendations of care for care into the EMR
- Enter medication orders on behalf of providers

**Scribe Documentation:** If the encounter note was written by a scribe, the scribe must sign the note and indicate that they were acting as a scribe. For example: “Written by xxx, (title), acting as scribe for Dr. XXX”

**Provider Documentation:** The provider should include a statement that they reviewed the documentation, and attest to the accuracy of the note. The provider may add to the note if additional information is needed. The provider then co-signs the note. *See Policy ADMIN 0268/SYS 014 Documentation of Care Health Related Data by Scribes.*
Knowledge Review

- Edit encounters when using Copy/Paste
- Avoid Note Bloat by limiting auto-populating data
- Be cautious in the use of Make Me the Author functionality
- Remember to: review, revise and update for the current encounter’s visit
- Medical students can only document ROS and PFSH
Medicare Incident-To Rules
Incident-to services are integral to the physician's service

**Incident To** services are defined as those services that are furnished incidental to physician professional services in the physician’s office.

- Medicare pays 100% of the physician’s fee schedule for services performed by advanced practice practitioners (APPs), such as Physician Assistants or Nurse Practitioners, if the services are “incident-to” a physician’s professional services.

- NC Medicaid no longer allows Incident-to billing for NP, PA, CRNA, and CNM.
Incident-to is a compliance risk area

Incident-to billing is a significant compliance risk area and sometimes leads to false claims allegations due to the complexity of meeting the regulatory requirements.

Incident To Requirements:

- The APP may carry out the treatment plan and bill incident to only for an established patient with an established diagnosis. If the APP creates the treatment plan, incident to requirements are NOT met.
- For a new patient, the physician must personally perform a face-to-face service and create the treatment plan.
- The physician must see the patient for new problems and establish the treatment plan.
- Physician remains involved in the care and amends the treatment plan.
Incident-to rules must be followed to bill for those services

- Services and supplies must be an integral, although incidental, part of the service of a physician (or other practitioner) in the course of diagnosis or treatment of an injury or illness;

- Physicians must provide direct supervision, which means being in the office suite while services are performed and immediately available to step in if the patient needs physician intervention;

- The physician must establish a treatment plan and provide the initial service; APPs may perform subsequent services as long as the physician sees the patient as often as reasonable and necessary.
Incident-to compliance pointers

- Palmetto GBA, the Medicare Administrative Contractor (MAC) for North Carolina has stated that incident-to billing is inappropriate for a new procedure, problem or condition and that the patient must be seen by the physician.

- Incident-to billing can only take place in a Physician office clinic (POS 11).

- The physician providing direct supervision of the APP in the clinic must be the physician that the incident-to services are billed under.

- NC Medicaid does not allow an APP to bill incident to a physician.
Incident-to documentation requirements must be followed to bill for those services

Documentation requirements:

- Physician has face-to-face encounter with a new patient or an established patient with a new condition.
- Physician remains active in subsequent care under the treatment plan.
- Physician was present and available in the office suite.
- Name and professional designation of provider rendering the incident-to service.

Compliance Handout: Incident-To Billing
Knowledge Review

- Incident-to can only be billed in a Physician Office (POS 11)

- Incident-to requires the billing physician to provide direct supervision and be in the office suite when services are rendered.

- MD must see all new patients or established patients with new problems for Incident-to

- NC Medicaid does not allow Incident-to billing for PA, NP, CRNA, or CNM
Medicare Regulations for Shared Visits with an APP
Shared Visits are a shared patient encounter between the MD and APP in a facility setting

- Shared visits apply to the following settings:
  - Hospital inpatient
  - Hospital outpatient
  - ED

- Shared visits cannot be billed in a physician-based clinic (POS 11).

- When a split/shared visit between an APP and a physician occurs in the office or clinic setting (not hospital-based), the service may be considered to be performed “incident-to”, if the incident-to requirements are met.
The following APPs are eligible to bill for shared visits within their scope of practice: Nurse Practitioners; Physician Assistants; Certified Nurse Specialists; and Certified Nurse Midwives.

- APPs must be from the same group practice as the physician.

- Both the physician and the APP must each personally perform a substantive portion of an Evaluation and Management (E/M) visit face-to-face with the same patient on the same date of service.

- It is NOT a shared visit if the physician participates in the service but does not perform and document the face-to-face encounter.
Shared Visits must be medically necessary

- A substantive portion of an E/M visit involves at least ONE of the three key components:
  - History
  - Examination
  - Medical Decision Making

- It must be medically necessary for both the physician and the APP to see the patient on the same day.

- Shared visits cannot be performed for nursing facility services or critical care.
Shared Visit documentation requirements must be met to bill for those services

- Providers may utilize the .att statement (smart phrase) in EPIC notating: “It was medically necessary for me to see the patient because ***. My visit included ***.”

- The medical record should link the APP and the physician notes.

- A physician co-signature alone or statement, such as, “Agree with the above” is not sufficient.
Knowledge Review

- Shared Visits are performed on inpatient services, in outpatient hospital clinics, or in the ED on the same date of service.

- MD must perform and document one of the following:
  - History
  - Exam
  - Medical Decision Making

- Documentation must demonstrate MDs face-to-face involvement and medical necessity of the shared visit.
Contact Us—We are here to help!

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