General Documentation Compliance
Review for Provider Reappointment

May 2018
Objectives

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

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

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

4. 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?

- **Ethic 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 $11,181 to $22,363 (2018 inflation adjustment)

**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 must prosecute all individual employees where there is sufficient evidence to do so.

- Previously, the DOJ generally did not pursue 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

- 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 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 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 14 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 HC

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 inaccurate billing to Medicare

“Make-me-the-author” tool
Allows a provider to substitute their signature for that of another person who entered notes in the EHR.

• Medical Students
  – The tool is particularly problematic if physicians become the author of medical student notes without verifying (and editing) the documentation and adding an attestation to the documentation. CMS requires:
    The teaching physician to verify all student documentation or findings, be physically present with the student, and perform (or re-perform) the physical exam and medical decision making. Use an approved Epic@UNC attestation to demonstrate meeting these rules.

• Resident Physicians
  – Do not use this functionality with Residents. Make-me-the-author does not replace the attestation requirement for a Teaching Physician working with a Resident Physician as make-me-the-author 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

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 upcoding 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 is not specific to the current patient encounter.

- Patient care could be compromised if old treatment plans are copied and pasted.
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

### 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>
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</thead>
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<tr>
<td></td>
<td>EHR</td>
<td>Paper Medical</td>
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<td>4 out of 8</td>
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<tr>
<td>MAC</td>
<td>4 out of 8</td>
<td>6 out of 8</td>
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<td>ZPIC</td>
<td>3 out of 6</td>
<td>6 out of 6</td>
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<tr>
<td>RAC</td>
<td>2 out of 4</td>
<td>3 out of 4</td>
</tr>
<tr>
<td></td>
<td>1 out of 4</td>
<td>3 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 that 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.
UNC HC’s policy reflects both the usefulness and potential risk of copy/paste

- Summarizing findings and medical judgment 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 medical students without verifying
  - Any contribution and participation of a medical student to the performance of a billable service (outside the collection of the system review and history) must be performed in the physical presence of a TP or a Resident.
  - The Teaching Physician or Resident must verify in the medical record all student documentation or findings.
  - The Teaching Physician must personally perform (or re-perform) the physical exam and medical decision making, but may verify any student documentation, rather than re-documenting this work.

UNC HC Policy: SYS 11 Copy/Paste Policy
Tips to avoid re-entering documentation

• For physical exams performed that were identical in scope and findings, make a statement in the current notes:
  – “Same exam performed as on 1/15/18 with same findings as below.”

• You may refer to material reviewed in Epic instead of entering specific detail into the note:
  – “Medication list an 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 care or observations, impressions, or recommendations of care into the EMR.

**Scribe Documentation:** If the encounter was written by a scribe, the scribe must sign the note and indicate that they were acting as a scribe.

- *For example:* “Entered by xx, (title), acting as scribe for Dr. Z. Signature (of scribe) Date (xx/xx/xxxx) Time (xx:xx)”

**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.

- *For example:* “The documentation recorded by the scribe accurately reflects the service I personally performed and the decisions made by me. Signature (of provider) Date (xx/xx/xxx) Time (xx:xx)”

See Policy [ADMIN 0268/SYS 14](http://example.com) 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 student documentation must be verified by the Teaching Physician and attested to
Medicare Incident-to Rules
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 (or other practitioners) 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/practitioner intervention;

The physician (or other practitioner) must establish a treatment plan and provide the initial service.

Auxiliary staff billing incident-to a physician/practitioner may not bill an Evaluation and Management service higher that CPT 99211.
Incident-to is a compliance risk: pointers for billing

• 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 take place only in a physician office clinic (POS 11).

• The physician (or non-practitioner) providing direct supervision to auxiliary staff in the clinic must be the physician/practitioner that the incident-to services are billed under.

• NC Medicaid does not allow an APP to bill incident-to a physician.

• UNC HC entities **do not allow** APPs to bill incident-to the physician. If a visit is shared between the APP and the physician for Medicare, Medicaid, or TRICARE patients, the service must be billed under the APP.

• [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 (or other practitioner) to provide direct supervision and be in the office suite when services are rendered.

- NC Medicaid does not allow Incident-to billing for PA, NP, CRNA, or CNM.

- Most UNC HC entities do not allow an APP to bill incident-to a physician for Evaluation and Management services.
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.
Shared Visits require both APP and MD documentation of the face-to-face encounter

- 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 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 involved at least ONE of the three key components:
  - History
  - Examination
  - Medical Decision Making

- It must be medical 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 noting: “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.

Compliance Handout: Shared Visits
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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