E-BRIEF SERIES

Healthicity

3 Common Risks in Healthcare Documentation

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Education related to documentation in the patient electronic medical record (EMR) is an area of health information management overdue for a tune-up. Lack of regular and formal education in this area poses a problem for healthcare providers who are expected to appropriately record information in the EMR every day for a variety of patients, conditions, and situations. As health information management professionals, we must better communicate useful solutions to common, but lesser-known documentation compliance errors that may invite unwanted risk into the medical record.

Let's explore specific, real-time compliance risk examples that may hide in daily workflows from the perspective of a chart auditing expert.

Risk #1: Preloaded time in EMR templates.*

If any of the EMR templates or Smartphrase lists in your organization look similar to the example below, the author may have inadvertently set themselves up with an easily avoidable compliance risk:

"Time spent in patient care activities on this date of service was 40 minutes."

As a best practice measure, **enter actual time into EMR templates or Smartphrases at the conclusion of the visit or date of service**. As a best practice measure, enter actual time into EMR templates or Smartphrases at the conclusion of the visit or date of service. Preloading a time statement may help the provider remember how much time he or she must spend to bill a certain E/M level, but it also puts the provider at risk of forgetting to adjust time documented in the template if the appropriate threshold was not truly met. This could cause a cluster of headaches, including questioning of documentation integrity, inaccurate documentation, legal or compliance issues, and/or loss of patient trust.

Consider a dilemma where numbers do not add up, such as when a physician has seen twenty-five clinic patients in one day and each record contains a preloaded time statement of 40 minutes (totaling 1,000 minutes, or just shy of 17 hours spent in direct patient care in one day). Tracing the problem back to a simple cloned documentation error could reveal a devastating mistake. Repercussions to suspicious use of time-based billing such as this could include a third-party payer time-based billing audit accompanied by costly overpayment refunds.

Penalties or overpayment refunds for inappropriately used cloned documentation related to the example above could be on the table as well. The local Medicare Administrative Contractor (MAC) in my area, National Government Services (NGS Medicare), states: "Documentation is considered cloned when it is worded exactly like or similar to previous entries. It can also occur when the documentation is exactly the same from patient to patient. Individualized patient notes for each patient encounter are required."[1] My personal interpretation of this statement is that this MAC would not consider identical time statements on multiple patient charts over any period of time as acceptable documentation.

Another important item to consider is that data transparency is a forceful initiative thanks to laws like the Health Insurance Portability and Accountability Act (HIPAA). HIPAA enables patients to review their own medical records with few restrictions. If a patient routinely reviews his or her medical records and notes inaccuracies or irregularities related to time documented as spent in care, the risk of eroding trust between patients and their healthcare providers significantly increases, potentially impacting quality of care and overall patient satisfaction.

[1] Documentation - NGSMEDICARE

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Lastly, in more recent EMR technology advances, vendors have installed visible timeclocks to help the documenting provider track time spent in the patient's record. While this advance was meant as a simple tool for timekeeping, there are clear drawbacks. Is the timeclock truly useful if the provider has multiple charts open at the same time? What if the provider takes an urgent phone call related to another patient while the first patient's patient chart is still open with the timeclock ticking? Both scenarios here are examples of overlapping time between multiple patients which cannot be documented and counted towards time-based billing.

The best practice suggestion from this auditor is to leave time-based EMR templates and Smartphrases blank or flagged with placeholders for easy editing so the user can fill in the appropriate data at the conclusion of the visit or at the end of the day. Additionally, use EMR timeclocks with caution and consider adopting and educating using any of the methods below:

- Fill in total time manually after the visit or at the conclusion of the date of service.

  Example:
  *"Time spent in patient care activities on the date of service above was **XX** minutes."*

- Fill in start/stop time after the visit.

  Example:
  *"**XX:XX – XX:XX** spent in direct patient care, including _____, _____, and _____."*

- Fill in itemized time after the visit or at the conclusion of the date of service.

  Example:
  *"**XX** minutes spent in chart review prior to patient visit.*

  ***XX** minutes spent in face-to-face discussion with the patient.*

  ***XX** minutes spent in post-visit charting.*

  ***XX** minutes spent discussing care with ____ via phone."*

One size does not fit all when it comes to time statements. It is highly suggested to tailor the examples above to the needs of the provider when documenting personal time spent toward patient care for appropriate E/M level reimbursement.

Need reinforcement when communicating to healthcare providers or leadership? A good place to start is your local Medicare Administrative Contactor (MAC)'s website for more specific guidance on time-based billing and documentation requirements.

**Reminder: This article focuses on time-based billing for physician or Advanced Practice Providers (APP) Evaluations and Management (E/M) services. Using medical decision making to level and E/M service versus time-based billing is still acceptable.*

Risk #2: Outdated language in EMR templates.

- *"Telehealth was performed due to the COVID-19 pandemic."*
- *"Over 50% of the visit was spent in counseling/coordination of care."*
- *"12-point review of systems (ROS) performed, otherwise negative."*

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While the three examples above may seem rather benign, the bottom line is these blanket phrases use outdated language. As an auditor, seeing routine phrases such as these signal a red flag in effective communication on current coding and documentation guidelines to physicians and/or Advanced Practice Professionals (APPs) within the organization.

The time of drafting this article is July 2024. The US Federal COVID-19 Public Health Emergency (PHE) officially ended May 11th, 2023. Yes, even now we still see patient records that state telehealth was "performed due to the COVID-19 PHE".

The reason for telehealth can no longer be due to the COVID-19 PHE.

This is a strong reminder that services must still be medically necessary, but the reasons for telehealth have evolved. Patients may seek care via telehealth for convenience because the patient is unable to leave his/her home due to significant medical problems or he/she experiences transportation limitations. The point is that patients may engage their healthcare providers for telehealth services for many reasons. Unless the patient has a COVID-19 infection and it is the decision of the healthcare provider and the patient to opt-out of presenting to the office in person, using this specific statement is misleading and should not be included in the medical record.

Another prime example of outdated language is: "___ minutes spent in patient care, over 50% in counseling and coordination of care". In 2021, the American Medical Association (AMA) revised the Evaluation and Management (E/M) documentation guidelines. These revisions allowed physicians and APPs to document office and outpatient visits based on either Medical Decision Making (MDM) or total time spent on the encounter, without the need to include counseling and coordination of care in the documentation.[2]

50% of visit time spent in counseling and coordination of care is no longer required for time-based billing.

If billing based on time, the healthcare provider should include the total amount of time spent in patient care on the date of service, whether this is face-to-face with the patient or in other activities, such as chart prep, chart review, placing orders, or other tasks specified by the AMA. The easiest way to do this is to create an itemized list to identify how much time was spent in each qualifying activity and include the total number of minutes to justify billing the corresponding E/M level. This is a reminder that time applies only to actual time spent on the date of service that the patient was seen – not the day before or after. Additionally, time used cannot overlap with other services that fall under the description of another billing code (such as reading an EKG or providing Remote Patient Monitoring (RPM) services).

The last risky blanket statement seen often in medical record documentation is: "*12-point ROS completed and otherwise negative*" or something similar. In the auditing world, we consider this a "cheat" blanket statement. But it is also a liability if all ROS are not truly accounted for during the patient visit.

Consider a patient care situation in which an orthopedic physician documents "*12-point ROS completed and otherwise negative*" but does not review all systems as stated. Later that day, the patient winds up in the hospital after suffering a stroke. Is the physician liable for missing symptoms documented as "otherwise negative" earlier that day? Overlooking this risk is something I assume most healthcare providers would rather not take.

A medically appropriate ROS should be captured and documented.

Along with time-based billing changes in 2021, the AMA removed the requirement for a detailed review of systems and a

[2] Documenting time for specific tasks per 2021 E/M office or other outpatient coding changes | AMA (ama-assn.org)

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comprehensive history for billing purposes. Rather, the physician or APP should document a medically appropriate history and ROS. For a dermatologist, a ROS involving the skin may be the only element necessary to be documented – which is acceptable per the 2021 AMA guidelines. It is not necessary for an ophthalmologist to be routinely reviewing patient gastrointestinal symptoms....you get the idea.

The best practice suggestion from this auditor is to, at the very least, annually review and revise EMR templates that are frequently used in any location where healthcare providers are giving care to patients. Consider engaging help from the local HIM, IT, or CDI department to assist with achieving template integrity and complying with current coding and/or CMS guidelines.

In summary, using outdated language in EMR templates can create extraneous information, or even threaten note quality and patient care. It is important to align EMR templates with current medical practices and regulatory requirements to promote precision, clarity, and relevance. Additionally, this effort assists with ensuring legal compliance, minimizing liability, as well as avoiding misunderstandings or misinterpretations.

Risk #3: Conflicting information in EMR documentation.

Conflicting documentation in physician or Advanced Practice Provider (APP) SOAP notes is a significant issue that can lead to miscommunication, errors in patient care, and challenges in medical coding. SOAP notes, which stand for Subjective, Objective, Assessment, and Plan, were designed to provide a structured and comprehensive record of a patient's visit to a healthcare provider. Addressing discrepancies is crucial for ensuring accurate and effective patient care, as well as maintaining the integrity of medical records.

Let us start with a game. What compliance risks can the reader spot in the following SOAP note?

CHIEF COMPLAINT: HEADACHES

Subjective:

Mrs. Smith is a 25-year-old male who presents today with a two-week history of constant, dull, aching head pain. She indicates that she has never struggled with headaches. He has tried Tylenol with minimal relief. She presents to our clinic today as a new patient inquiring about other treatment options. She shares that she started a new job as a school secretary in this two-week period, working approximately 30 hours a week with more than 75% of that time spent in screen-type work. Prior to that, she was employed as a cashier at the local Jewel.

Objective:

Vital signs recorded for today's visit: BP 120/76, height 8'6", weight 125 pounds, BMI 8.4, pulse 72 bpm.

AAO x3, well-nourished female patient who appears appropriate for stated age.

Upon examination, no abnormalities noted for the following: Auscultation of the heart and carotid arteries around eyes, palpitation of the temporal arteries, and examination of the lungs. No obvious trauma or infection detected. No stiffness or tenderness in muscles of head and neck. Palpitation of thyroid gland and TMJ were unremarkable.

There is no imaging on file to review, patient does not recall any previous MRI, CT, or X-rays.

Assessment:

Tension Headaches

Plan:

Consider switching to alternate OTC medication: naproxen sodium (Aleve) or ibuprofen (Motrin). Suggested massage

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therapy, reduction in screen time at work, ergonomic workstation assessment, hot/cold compresses for mild neck tenderness, and continued exercise with light stretching. Follow up with office if no resolution of symptoms within 1 week.

CODING:

G43.709 Chronic migraine without aura, not intractable, without status migrainosus

99202 New patient office or other outpatient visit, 15 minutes met or exceeded for time based-billing

To the untrained eye, the note and coding for the medical claim above may look satisfactory. To a medical record auditor, there are multiple concerns regarding conflicting documentation and overall documentation integrity. Here is general breakdown of 4 core audit findings:

1. **SUBJECTIVE SECTION: GENDER CONFUSION**

   While documenting "he" instead of "she" is a common mistake, nonetheless, it is still conflicting information that could put the integrity of the documentation into question by another healthcare provider, third-party reviewer, or even the patient. Reminder that patients can now view their own medical records (with some exceptions). To build trust and respect with the patient in the current medical landscape, it is important to not only discuss their gender at birth and current pronoun preference, but to document it accurately as well.

2. **OBJECTIVE SECTION: HEIGHT ENTRY DISCREPANCY & BMI MISCALCULATION**

   Note the error which states the patient stands 8ft 6in, which resulted in a miscalculated BMI of 8.4 (severely underweight). Most EMR systems have a failsafe included to prevent these types of errors from landing in patient notes permanently, but what if this is not a feature included in the EMR of choice for your organization? With a small mistype, data is now skewed, and an inaccurate diagnosis posed (which was neither noted nor addressed during the visit – the physician even documented that the patient appeared to be "well-nourished").

   The suggestion from this auditor is to ensure failsafe features such as data validation rules and alerts/warnings are part of any EMR system being utilized by the organization, as well as staff training on manually double-checking entered vitals to ensure accuracy.

3. **PLAN SECTION: SYMPTOM NOT DOCUMENTED IN PHYSICAL EXAM**

   This one is tricky, but important. No neck tenderness was documented as present in the Objective section of the documentation but was clearly documented in the Plan. Scenarios such as this usually mean there was an oversight in updating templated information. The result is conflicting information in the record. This particular example is straightforward, but if a more complicated condition were addressed, it would most likely result in a coding or CDI query before the claim can be processed. Consistency throughout the note is key.

4. **CODING SECTION: BILLING DIAGNOSIS DOES NOT MATCH SOAP NOTE DOCUMENTATION**

   Another common audit finding and perhaps the most important to avoid; the physician's documentation clearly states the final diagnosis as tension headaches (ICD-10 code G44.209), but the billing diagnosis submitted on the claim was chronic migraines (ICD-10 code G43.709). In many EMR systems, the billing diagnosis is part of the SOAP note. Conflicting diagnoses in the same SOAP note or between the SOAP note and the insurance claim will most likely result in a coding or CDI query prior to submission

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to an insurance company. This example error is again minor, but what if the difference in the diagnoses had been a hierarchical condition category (HCC) code vs. a non-HCC code for a value-based care patient? A small oversight can have large consequences in the world of VBC where diagnosis accuracy is crucial to physician compensation. On the other hand, what if the patient was told by her physician that she had tension headaches, but was confused when she saw that the medical record states she has chronic migraines via her patient portal? Again, for multiple reasons, consistency is key.

Hidden documentation compliance risks can lurk anywhere in the EMR system. Addressing human error regarding conflicting EMR documentation is essential to prevent miscommunication, ensure accurate patient care, and maintain the integrity of medical records. By resolving discrepancies in SOAP notes and taking EMR documentation integrity seriously, healthcare providers can enhance the quality and reliability of documentation in the patient record.

Conclusion:

Accurate, individualized documentation is essential for compliance, patient trust, and proper reimbursement. Even well-meaning shortcuts like preloaded time statements can introduce significant risk if not managed carefully. By staying vigilant and adopting best practices, healthcare providers and professionals can strengthen documentation integrity and reduce exposure to costly errors.

Risks Recap

Risk #1:

Preloaded time in EMR templates.*

Risk #2:

Outdated language in EMR templates.

Risk #3:

Conflicting information in EMR documentation.

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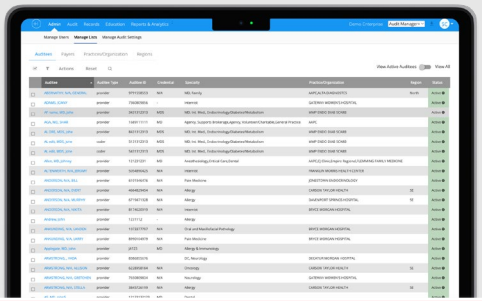

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