E-BRIEF SERIES

Healthicity

Hidden Documentation Compliance Risks: Part 1

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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.

In this series, we explore specific, real-time compliance risk examples hiding in daily workflows from the perspective of a chart auditing expert. The reader will walk away with simple, reliable guidance to help mitigate these risks and assist in the effort toward better medical record documentation education for our healthcare providers.

The first documentation risk example: 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**. 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

[1] Documentation - NGSMEDICARE

eroding trust between patients and their healthcare providers significantly increases, potentially impacting the quality of care and overall patient satisfaction.

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.*

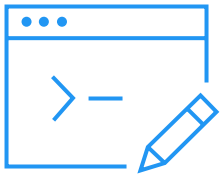
  ***XX** minutes spent in post-visit charting.*

  ***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 Contractor (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.*



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Kristen Poat is an RHIT certified through AHIMA and CHPC through HCCA with 12 years' experience in various roles in the auditing, coding, and compliance environments. She currently serves as a coding compliance educator and subject matter expert who takes a special interest in outpatient physician multi-specialty clinic and ASC settings. Kristen holds memberships with AHIMA, ILHIMA, and HCCA. She aspires to return to school to obtain her RHIA certification and next-level degree.

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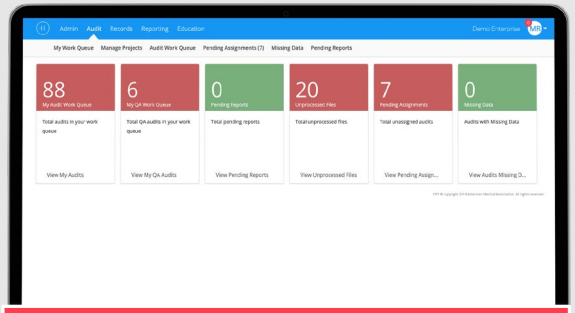

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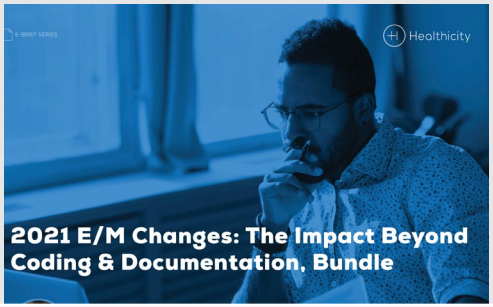

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